

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08121

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 10-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 125 Clarke Place				d. STREET ADDRESS 125 Clarke Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LLOYD A. AMBROSEN				4. DATE OF DEATH Month Day Year June 18 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1913 54	
9. AGE (In years lost birthday) yrs. 54		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Md. School for Deaf		11. BIRTHPLACE (State or foreign country) Winona, Minnesota	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Gullick Ambrosen			
14. MOTHER'S MAIDEN NAME Florence Blanchard				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.#2			
16. SOCIAL SECURITY NO. 476 18 3810				17. INFORMANT Mrs. Mary Ambrosen (Same as item # 2)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Artery Occlusion - Myocardial infarction DUE TO (c) Arterio-sclerotic Cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Winona, Minnesota	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE JUN 20 1967			

2316

TSIRO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08136						08122					
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 9 N. Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James First Adrain Middle Baker Last			4. DATE OF DEATH June 29, Month 19 67 Day Year								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1884		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 7 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Loudon Co., Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles W. Baker						14. MOTHER'S MAIDEN NAME Mary K. Cooper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 520-77-2944		17. INFORMANT 1400 Kinwick lane Md. Mrs. Evelyn B. McAllister, Silver Spring,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Arteriosclerotic Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										INTERVAL BETWEEN ONSET AND DEATH 	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/23/67 , 19 67 to 6/29/67 , 19 67 , that (I) (we) last saw the deceased alive on 6/29/67 , 19 67 , and that death occurred at 11:50am , from the causes and on the date stated above.											
22a. SIGNATURE Richard C. Reynolds						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/29/67			
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.						22d. ADDRESS Toll House Ave. Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-1-67		23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery			23d. LOCATION (City, town or county) (State) Rohrersville, Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR JUL 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

08138

08138

Robert C. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 3
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08137

CERTIFICATE OF DEATH

08123

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 306 Hill Street				d. STREET ADDRESS 306 Hill Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GILMORE Middle A. Last BECRAFT				4. DATE OF DEATH Month June Day 9 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1889		
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trackman			10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Becraft				14. MOTHER'S MAIDEN NAME Fannie ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-8476		17. INFORMANT Mrs. Della B. Becraft Same As #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Dis. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1955, to _____, 1967, that (I) (we) last saw the deceased alive on May 8 1967, and that death occurred at 7 A. M, from causes and on the date stated above.								
22a. SIGNATURE W.B. Culwell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/9/67		
22c. PHYSICIAN'S NAME (Type) W.B. Culwell				22d. ADDRESS Mt. Airy, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/1967		23c. NAME OF CEMETERY Pine Grove		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.		
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.				25. REC'D BY REGISTRAR JUN 14 1967		25. REGISTRAR'S SIGNATURE Charles Judge		

08180

08180



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08124

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>West Virginia</u> COUNTY <u>Morgan</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkley Springs</u> 85-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Rt #1</u>	
3. NAME OF DECEASED (Type or print) <u>Michael</u> First <u>Benedikt</u> Middle <u>Benedikt</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sheet Metal Worker David Taylor Model</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Basin</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johann Benedikt</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Shretter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Josephine M. Lane</u>		Address <u>10817 Margate Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Shock - Blood loss</u>			
DUE TO (b) <u>Ruptured Aorta</u>			
DUE TO (c) <u>Fractured Ribs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Six car collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 p.m. 6-22-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>M. Frederick Frederick - Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert J. Thomas</u> M.D.		22. DATE SIGNED <u>6-22-67</u>	
EXAMINER'S NAME (Type) <u>ROBERT J. THOMAS, M.D.</u>		Address (Street, city, town, or county) <u>8434 Georgia Avenue Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		DATE <u>JUN 28 1967</u>	

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08133

Item #3 Film #G392 8/6/67 ph

CERTIFICATE OF DEATH

08125

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN TB Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 501 Pearl Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Elizabeth Betson First Elizabeth Middle Betson Last Lost a/k/a Elizabeth Albaugh Betson				4. DATE OF DEATH Month June Day 1 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 15, 1913	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator		11. BIRTHPLACE (County & State, or foreign country) M. J. Grove Line Co. Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ingomar W. Albaugh				14. MOTHER'S MAIDEN NAME Oma C. Willett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578 07 7741		17. INFORMANT Richard K. Betson, Edgemont Rd. Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral valve disease of heart 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August , 19 66 , to June , 19 67 , that (I) (we) last saw the deceased alive on June , 19 67 , and that death occurred at 6 M. from causes and on the date stated above.							
22a. SIGNATURE GILGIN F. MEADORS, MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/1/67	
22c. PHYSICIAN'S NAME (Type) GILGIN F. MEADORS, MD				22d. ADDRESS 810 TOLL HOUSE AVE. FREDERICK, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Nr. Hansonville, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08140

CERTIFICATE OF DEATH

Reg. Dist. No.

08126

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodboro</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Woodboro</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETTY MAE BIDDINGER</u>		4. DATE OF DEATH Month Day Year <u>June 16 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30, 1931</u>
9. AGE (In years last birthday) <u>35 yrs.</u>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Leslie Biddinger</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Munshower</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Carrie M. Biddinger, Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 7441 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic respiratory failure</u> DUE TO (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>3 weeks</u> <u>27 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that I attended the deceased from <u>6-18-67</u> to <u>6-16-67</u> , that I last saw the deceased alive on <u>6-16-67</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Love</u>		ADDRESS (Street, city or town, state) <u>Thurmond, Md.</u>	
DATE SIGNED <u>6/17/67</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS A. LOVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Libertytown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>		ADDRESS <u>Walker, 21793</u>	
24a. RECEIVED BY REGISTRAR DATE <u>JUN 20 1967</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	

88.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>08141</p> </div> <div> <p>STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>08127</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>						c. LENGTH OF STAY IN 1b <u>1 day</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial Hosp.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Midway</u>					
3. NAME OF DECEASED (Type or print) <u>SYLVESTER ARNOPHIS BOSTIAN</u>						d. STREET ADDRESS <u></u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						4. DATE OF DEATH <u>June 22 1967</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>--</u>						14. MOTHER'S MAIDEN NAME <u>Laura Bostian</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>212-40-6233</u>					
17. INFORMANT <u>Mrs. Lola A. Bostian, Keupman, Md.</u>						Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage</u> DUE TO <u>Anterior-inferior cardio-vascular disease</u> (b) <u></u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1960</u> to <u>6/22</u> , 1967, that (I) (two) last saw the deceased alive on <u>6/21</u> , 1967, and that death occurred at <u>12:05</u> A.M., from the causes and on the date stated above											
22a. SIGNATURE <u>Ernest A. Dettbarn</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>6/23/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>						22d. ADDRESS <u>Wallerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cem</u>				23d. LOCATION (City, town or county) (State) <u>Woodsboro Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton, Wallersville, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

THE
FEDERAL
BUREAU OF
INVESTIGATION
UNITED STATES
DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535



08142

CERTIFICATE OF DEATH

08128

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home		d. STREET ADDRESS 48 E. South St.	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Bowers		4. DATE OF DEATH Month June Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6-1886
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles O. Phebus		14. MOTHER'S MAIDEN NAME Sarah E. Burrier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-28-5287	
17. INFORMANT Laurens N. Bowers- E. 7th. St.-Frederick-Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 15 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1965 to June 12, 1967 that (I) (we) last saw the deceased alive on June 11, 1967 and that death occurred at 10:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Bernard O. Thomas, Jr.		22b. DATE SIGNED June 13-67	
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr.		22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16-1967	
23c. NAME OF CEMETERY OR CREMATORY St. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR JUN 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

08143

CERTIFICATE OF DEATH

08129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Braddock Hgts.		c. LENGTH OF STAY IN lb 8 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Vindobona Nursing Home		e. STREET ADDRESS 104 Clarke Place	
3 NAME OF DECEASED (Type or print) First Viola Middle Rebecca Last Bowers		4 DATE OF DEATH Month June Day 11 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12- 1889
9 AGE (in years last birthday) yrs 77		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry W. Bowers		14. MOTHER'S MAIDEN NAME Anna Isabel Fox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-7559	
17. INFORMANT Mrs. Eliz. Ordman-104 Clarke Place-Frederick-		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral Cardiac failure 4-200 DUE TO (b) A-S. Hunt dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe intracerebral metastatic leukemia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 65 , to 11 June , 19 67 , that (I) (we) last saw the deceased alive on 8 June 19 67 , and that death occurred at 1:30AM , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr.		22b. DATE SIGNED June 12-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley-Jr.		22d. ADDRESS Professional Bldg.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 14-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR June 15 1967	
ADDRESS Whitmore Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Frederick, Md. 21701

June 14-1987 Mr. Oliver Geunsky

Frederick, Md. 21701

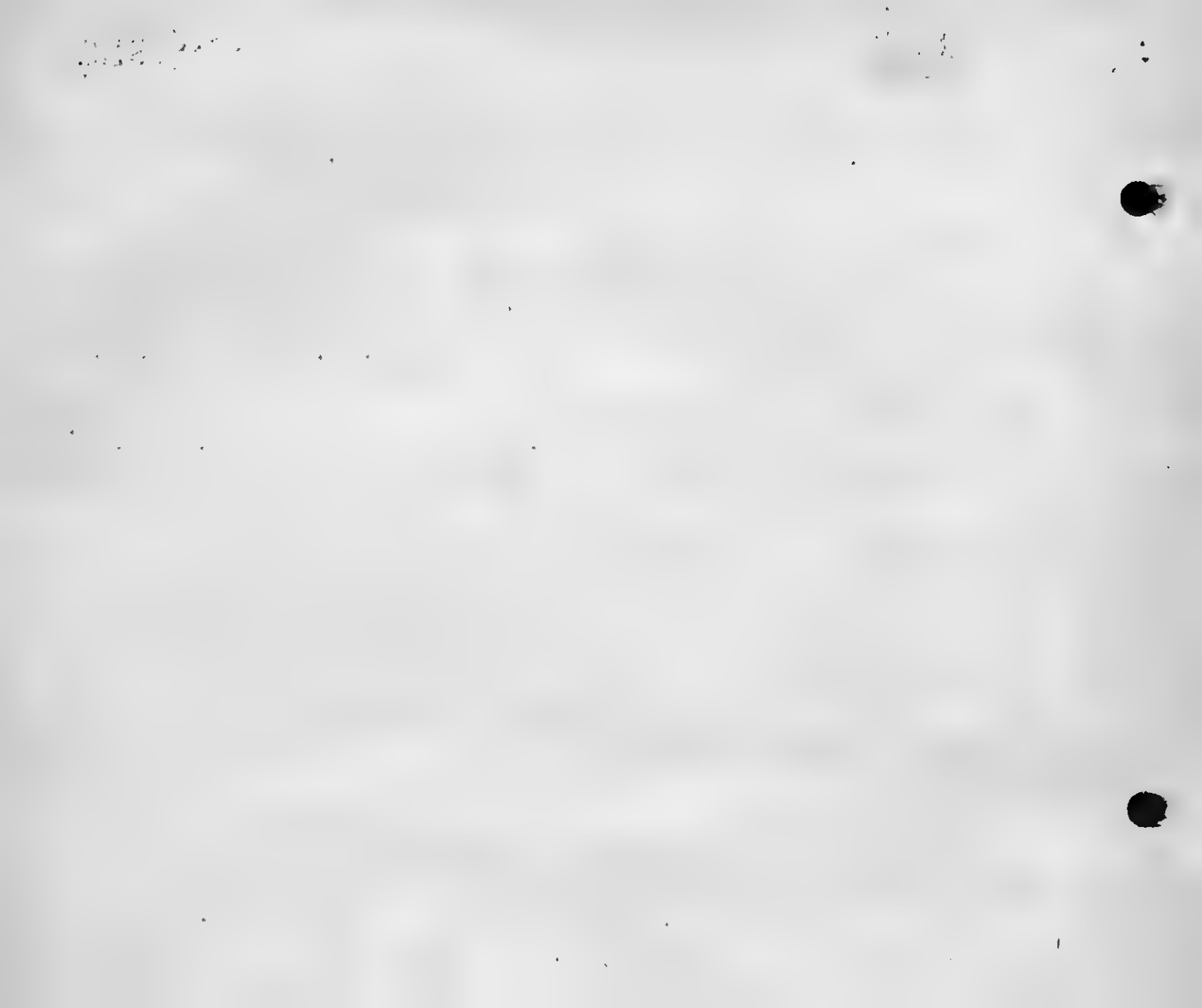
Frederick & Son

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08144		08130	
1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 1		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) First Middle Last Clyde Willis Boyer		4. DATE OF DEATH June 10 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18- 1905	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willis Boyer		14. MOTHER'S MAIDEN NAME Laura Haugh Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-28-1265	
17. INFORMANT Mrs. Frances Carpenter Boyer-Rt. 1-Mt. Airy-Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Bronchiogenic carcinoma DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 days about 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 26, 1966, to June 10, 1967, that (I) (we) last saw the deceased alive on April 29, 1967, and that death occurred at 11:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Ernest A. Dettbarn		22b. DATE SIGNED June 11-67	
22c. PHYSICIAN'S NAME (Type) ERNEST A. DETTBARN		22d. ADDRESS WALKERSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701	
24. FUNERAL DIRECTOR'S SIGNATURE A.R. Etchison & Son		25a. REC'D BY REGISTRAR JUN 15 1967	
ADDRESS T. Whitmore Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge	



08145

CERTIFICATE OF DEATH

08131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN IS 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Frederick d. STREET ADDRESS Route 7	
3. NAME OF DECEASED (Type or print) First Louis Middle Nichols Last Cole-Sr.		4. DATE OF DEATH Month June Day 20 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper Pbg.Co.	11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.
13. FATHER'S NAME Charles Edward Cole		14. MOTHER'S MAIDEN NAME Ida May Stoner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3065	
17. INFORMANT Louis N. Cole, Jr.		Address 905 Pontiac Ave.-Frederick Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 11-1-1965 to 6-20-1967 , that (I) (we) last saw the deceased alive on 6-14-1967 , and that death occurred at 12-30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin M.D.		22b. DATE SIGNED June 20-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		22d. ADDRESS 220 N. Market St.- Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 23-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) Frederick, Md. 21701 (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son		25a. REC'D BY REGISTRAR Elwood T. Whitmore 25b. REGISTRAR'S SIGNATURE Charles Judge DATE JUN 26 1967	

08146

CERTIFICATE OF DEATH

08132

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKY RIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ASA</u> Last <u>COLSON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 25 - 1875</u>
9. AGE (in years last birthday) <u>92</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WESTERN UNION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LINEMAN</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM COLSON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PICKETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-48-6412</u>	
17. INFORMANT <u>MRS HAROLD BOLLINGER</u>		Address <u>MD ROCKY RIDGE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dysrhythmias</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>General Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis of Aorta - Bicuspid Aortic Valve - Bicuspid Aortic Valve</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1963</u> , 19 <u> </u> , to <u>1967</u> , 19 <u> </u> , that (1) (we) last saw the deceased alive on <u>6-1-67</u> , and that death occurred at <u>4A</u> M, from causes on and on the date stated above			
22a. SIGNATURE <u>Thomas A. Love</u>		22b. DATE SIGNED <u>6-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas A. Love, M.D.</u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>DR. Hartzler & Sons New Windsor, Md</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08147		08133									
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u> c. LENGTH OF STAY IN b. <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty St.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u> d. STREET ADDRESS <u>Liberty St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD CONAWAY</u>						4. DATE OF DEATH <u>June 26 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1921</u>		9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Machinery</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jolley M. Conaway</u>						14. MOTHER'S MAIDEN NAME <u>Stella Poole</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>220-28-3009</u>		17. INFORMANT <u>Mrs Catherine Conaway, Walkersville, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Generalized carcinomatous</u>											
DUE TO <u>Carcinoma of transverse colon</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>June 26, 1967</u> that (I) (we) last saw the deceased alive on <u>June 25, 1967</u> , and that death occurred at <u>2:00</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Ernest A. Dettbarn</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/26/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>						22d. ADDRESS <u>Walkersville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glade Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Walkersville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Frank J. Judge</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md. 21793</u>						ADDRESS					

MEDICAL CERTIFICATION

08148

CERTIFICATE OF DEATH

08134

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Home		d. STREET ADDRESS 928 East 'A' Street	
3. NAME OF DECEASED (Type or print) JANE JEMIMA CRUMMITT		4. DATE OF DEATH Month 6 Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/95
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 16 Min 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Randolph Crum		14. MOTHER'S MAIDEN NAME Mary Elizabeth Baer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. A-214-10-3084	
17. INFORMANT Alonza Crummitt		Address Brunswick Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA DUE TO DIABETES DUE TO ASHD & CHF			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia UTI			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 , to June , 19 67 that (I) (we) last saw the deceased alive on 6/5/67 , 19 67 , and that death occurred at 12:20 PM , from causes on and on the date stated above.			
22a. SIGNATURE A. Austin Baer		22b. DATE SIGNED 6/8/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/9/67	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet	23d. LOCATION (City or Town) (County) (State) Frederick Md
24. FUNERAL DIRECTOR Frederick Funeral Home		25. REC'D BY REGISTRAR June 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08149

CERTIFICATE OF DEATH

08135

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Home		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CHARLES Middle E. Last DeGRANGE		4. DATE OF DEATH Month June Day 29 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1878
9 AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer own gen. farm	
10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11 BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David DeGrange	
14. MOTHER'S MAIDEN NAME Josephine Hoffman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 220-16-2790		17. INFORMANT C. Albert DeGrange, Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 5 years.		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1963 to June 29, 1967 , that (I) (we) last saw the deceased alive on June 29, 1967 and that death occurred at 3:44 A.M. from causes and on the date stated above.			
22a. SIGNATURE LeRoy T. Davis		22b. DATE SIGNED 6/29/67	
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis		22d. ADDRESS Frederick, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY United Brethern		23d. LOCATION (City or Town) (County) (State) Myersville, Fred. Co. Md.	
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JUL 3 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

08150

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08136

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Buckeystown				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				d. STREET ADDRESS Buckeystown			
3. NAME OF DECEASED (Type or print) First Anna Middle Laura Last Derr				4. DATE OF DEATH Month June Day 6 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30-1886		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Derr				14. MOTHER'S MAIDEN NAME Anna Mary Zimmerman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-2407		17. INFORMANT Address Mrs. C.E. Nichols-Buckeystown, Md. 21717			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bladder cancer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 , 19 62 , to 6-6- , 19 67 , that (I) (we) last saw the deceased alive on 6-4- 19 67 , and that death occurred at 7 p.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Rex R. Martin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 7-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin				22d. ADDRESS 220 N. Market St.-Frederick, Md. 21701			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Whitmore		25a. REC'D BY REGISTRAR JUN 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08151

CERTIFICATE OF DEATH

03137

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d STREET ADDRESS 141 East 6th Street	
3 NAME OF DECEASED (Type or print) First Austin Middle Curtis Last Devilbiss		4 DATE OF DEATH Month June Day 8 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 6, 1919
9 AGE (In years last birthday) 48 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff	
10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Curtis Devilbiss	
14 MOTHER'S MAIDEN NAME Roberta Powell		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 217-10-0390		17. INFORMANT Mrs. Mary G. Devilbiss Address 141 E. 6th St. Fred. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH	
Congestive Heart Failure			
Bronchiogenic Carcinoma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of Liver; Bleeding Esophageal Varices		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 57 , to 6-8- , 19 67 , that (I) (we) last saw the deceased alive on 6-7- 1967 , and that death occurred at 7:43 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Dr. Rex R. Martin		22b. DATE SIGNED 6-8-67	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.		22d. ADDRESS 220 N. Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24 FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REC'D BY REGISTRAR JUN 12 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2001.05.11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

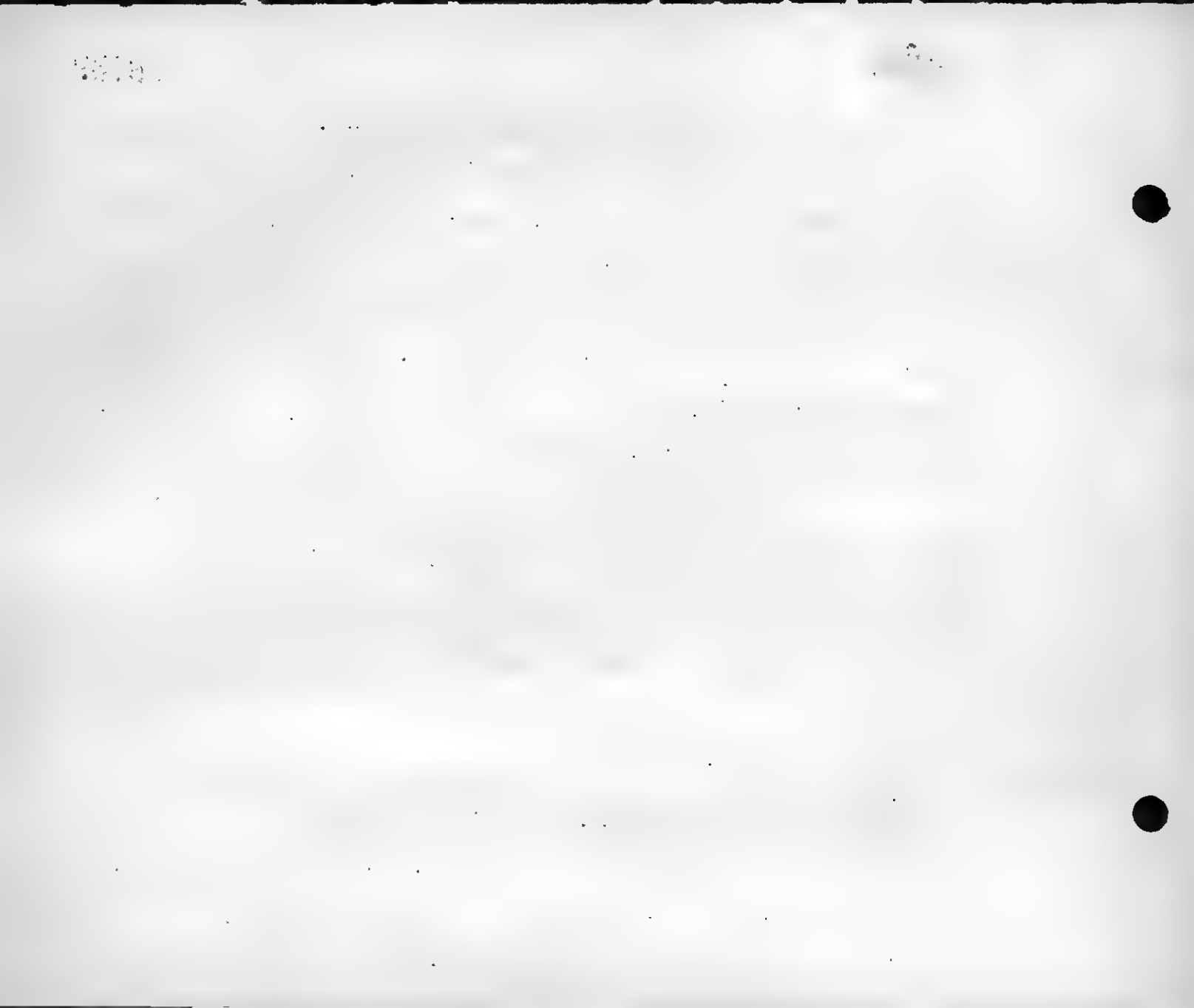
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08152

08138

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b <u>3 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FREDERICK MEM. HOSP.</u>				d. STREET ADDRESS <u>RT. #7 OLD RECEIVER RD.</u>			
3. NAME OF DECEASED (Type or print) <u>ETHEL</u> First <u>MAE</u> Middle <u>DREW</u> Last				4. DATE OF DEATH <u>6</u> Month <u>21</u> Day <u>1967</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-1901</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sorter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT PACKING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WELLSBORO PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES A. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>LEONA FRANCES FRENCH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>564-09-4074</u>		17. INFORMANT <u>MELVIN E. DREW</u>		Address <u>FREDERICK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerosis, cardiovascular + possibly cerebral vascular disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Obesity, exogenous, severe.</u> (c) DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>5-6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>67</u> to <u>6-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-12</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Rex R. Martin</u>				22b. DATE SIGNED <u>6-21-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Rex R. Martin</u>	
22d. ADDRESS <u>220 N. Market Frederick, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK MD.</u>	
24. FUNERAL DIRECTOR <u>SALAMONE FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>FREDERICK, MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 may be retained by the hospital or attending physician. Page 2 of 3 may be retained by the funeral director. Page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7-62

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08153
08139
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>909 Pine Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>909 Pine Avenue</u>		
3. NAME OF DECEASED (Type or print) <u>ROY HENRY DUTROW</u> 4. DATE OF DEATH <u>June 27 1967</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>March 16, 1891</u> 8. SEX <u>Male</u> 9. AGE (in years last birthday) <u>76</u> yrs. 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> 11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland State Roads</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick County, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Dutrow</u> 14. MOTHER'S MAIDEN NAME <u>Mary Manzella Ahalt</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>215 34 3422</u> 16. SOCIAL SECURITY NO. <u>215 34 3422</u> 17. INFORMANT <u>Mrs. Pearl Dutrow (Same as item # 2)</u> Address <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatous</u> 177X DUE TO <u>Prostatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1967</u> to <u>June 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1967</u> , and that death occurred at <u>8:30 P M</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>E. A. Dettbarn</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>6/28/67</u> 22c. PHYSICIAN'S NAME (Type) <u>E. A. DETTBARN, M. D.</u> 22d. ADDRESS <u>Wallonsville, Ind.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 30, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Middletown, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> 25c. ADDRESS <u>Frederick, Maryland</u> 25d. DATE <u>June 30 1967</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08154

08140

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Braddock</u>				c. LENGTH OF STAY IN IB <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Windobona Convalescent Home</u>				d. STREET ADDRESS <u>422 Sherman Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>RODNEY</u> Last <u>FOX</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1896</u>	
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>			
13. FATHER'S NAME <u>Hegckish Fox</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-03-5211A</u>		17. INFORMANT <u>Mrs Mildred E. Fox, 422 Sherman Ave., Fred. Md.</u> Address <u>md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKINSON'S Disease</u> DUE TO (b) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>5 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>6-7-1967</u> , that (I) (we) last saw the deceased alive on <u>6-5-1967</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>R. R. Martin</u>				22b. DATE SIGNED <u>6/7/67</u>		22c. PHYSICIAN'S NAME (Type or print) <u>Rex R. Martin</u>	
22d. ADDRESS <u>Frederick Md</u>				22e. REC'D BY REGISTRAR <u>Charles Jones</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town or county) <u>Woodsboro</u> (State) <u>md.</u>	
24. FUNERAL DIRECTOR <u>J. C. Barton, 40 Fulton Ave., Walkersville, Md.</u>				25. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

2000



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08155						08141					
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick c. LENGTH OF STAY IN b. years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 4						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick d. STREET ADDRESS Route 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harvey Rayue Fox						4. DATE OF DEATH June 7- 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27-1887		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Fox						14. MOTHER'S MAIDEN NAME Mary Atkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWar 1						16. SOCIAL SECURITY NO. 214- 16-0286					
17. INFORMANT Mrs. Helen Stokes Fox- Route 4-Frederick, Md.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis											
Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic C.V.D.											
(c) 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 2, 1955 to June 7, 1967 that (I) (we) last saw the deceased alive on June 2, 1967 and that death occurred at 6 p.m. from the causes and on the date stated above.											
22a. SIGNATURE B.O. Thomas Jr.						22b. DATE SIGNED June 8-1967					
22c. PHYSICIAN'S NAME (Type) Dr. B.O. Thomas Jr.						22d. ADDRESS Prof. Bldg., Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10-1967		23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		23d. LOCATION (City, town or county) Nr. Yellow Springs, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son						25a. REC'D BY REGISTRAR June 12 1967					
25b. REGISTRAR'S SIGNATURE Frederick, Md. 21701											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

08156

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08142

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b years		d. STREET ADDRESS 209 Rockwell Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA- Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel F. GARDNER Sr.		4. DATE OF DEATH June 1- 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7- 1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (County & State, or foreign country) Loch Haven- Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. F. Gardner		14. MOTHER'S MAIDEN NAME Margaret Roan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212- 05-0823	
17. INFORMANT Miss Helen M. Gardner-209 Rockwell Terrace-		Address Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension, Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension, Emphysema			
19. INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1962 , to May 1, 1967 , that (I) (we) last saw the deceased alive on June 1, 1967 , and that death occurred at 11:00 M, from the Causes and on the date stated above.			
22a. SIGNATURE Thomas L. Stone		22b. DATE SIGNED 6-1-67	
22c. PHYSICIAN'S NAME (Type) Thomas L. Stone		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR Elwood T. Whitmore		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 5 1967	

1. The first part of the document is a letter from the President of the United States to the President of the Senate, dated January 1, 1901. The letter is signed by William McKinley and is addressed to John Sherman. The letter is a copy of a letter that was sent to the President of the Senate by the President of the United States.

1. The first of these is the fact that the Commission has not yet received any information from the Government of the Democratic Republic of the Congo regarding the situation in the country.

08157

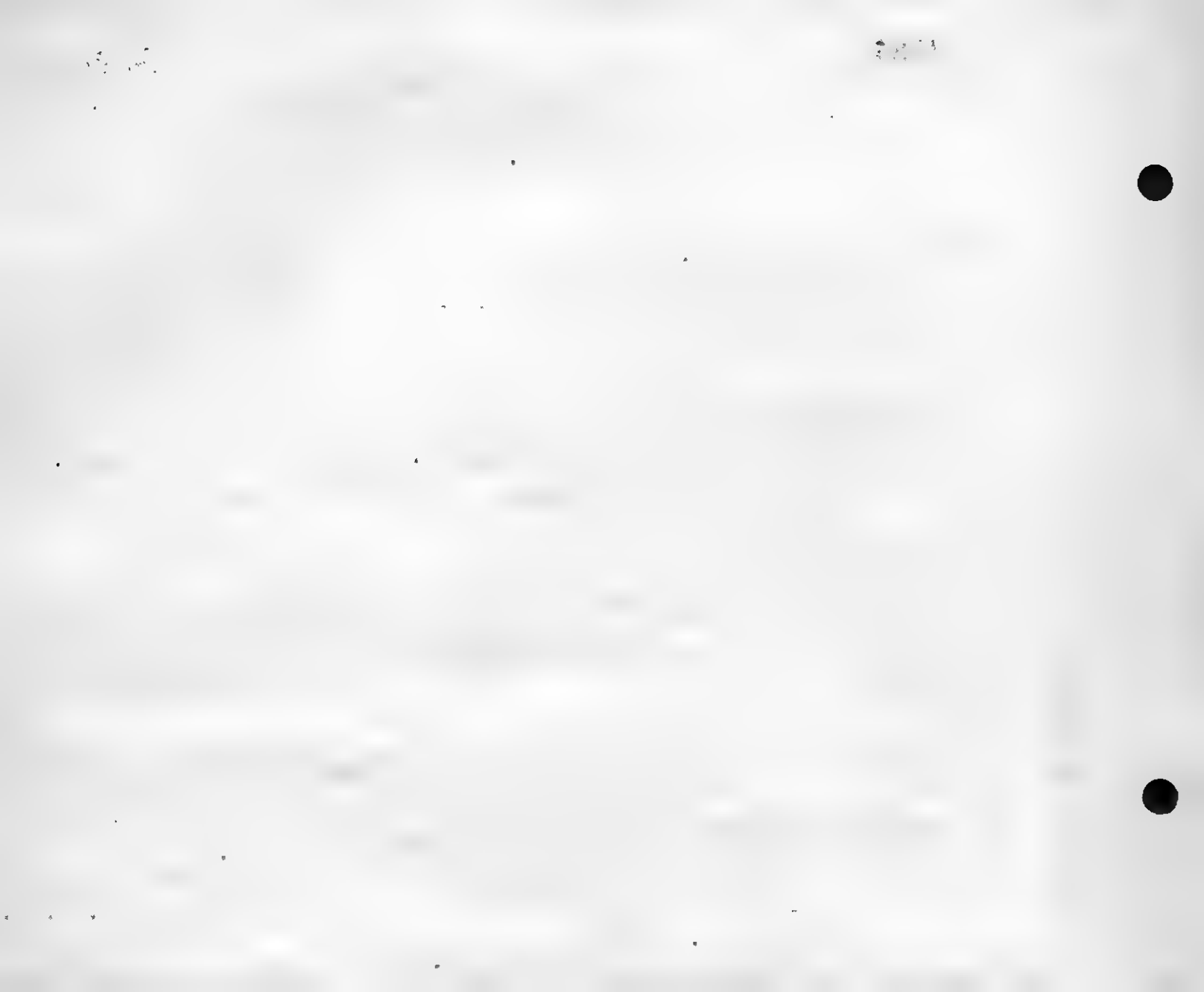
CERTIFICATE OF DEATH

08143

1. PLACE OF DEATH a. COUNTY Fredrick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c. LENGTH OF STAY IN 1b 17 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLIAM H. GEARHART		4. DATE OF DEATH Month June Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1903
9. AGE (In years last birthday) 63 yrs		10. UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Rented Farm	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Gearhart		14. MOTHER'S MAIDEN NAME Ida Cline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service) No		16. SOCIAL SECURITY NO 183-12-4698	
17. INFORMANT Harvey J. Gearhart		Address Rocky Ridge, Md. Rt. #	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO (b) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 1959 , 19____, to 4/18/67 , 19____, that (we) last saw the deceased alive on 4/18/67 , 19____, and that death occurred at 130 P.M. , from causes and on the date stated above.			
22a. SIGNATURE George E. Morningstar		22b. DATE SIGNED 4/24/67	
22c. PHYSICIAN'S NAME (Type) George Morningstar		22d. ADDRESS Emmitsburg, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-26-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery	23d. LOCATION (City or Town) (County) (State) Rocky Ridge Fred. Co. Md.
24. FUNERAL DIRECTOR Raymond E. Greager		25a. REC'D BY REGISTRAR Thurmont, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08144

1. PLACE OF DEATH a COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Frederick			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 Route 3				d STREET ADDRESS Route 3			
3. NAME OF DECEASED (Type or print) First Eva Middle Viola Last Gibbons				4. DATE OF DEATH Month June Day 25 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7-1902	9. AGE (in years last birthday) yrs 65	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Mayberry Giffit				14. MOTHER'S MAIDEN NAME Martha Ellen Holmes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-18-0485		17. INFORMANT Mrs. Maxine Staub- Route 3-Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASTHMA						9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas M.D.				22. DATE SIGNED 6/25/67			
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE JUN 28 1967		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08159

CERTIFICATE OF DEATH

08145

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residente before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Rural Emmitsburg,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Roy Franklin Glass				4. DATE OF DEATH June 20, 1967 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1902		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Farmer & School Bus		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lee Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Glass				14. MOTHER'S MAIDEN NAME Sarepta Orshorn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-32-6948		17. INFORMANT Mrs. Roy F. Glass, Emmitsburg, Md. R.D. #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO arteriosclerotic c.v. disease DUE TO Diabetes Mellitus INTERVA. BETWEEN ONSET AND DEATH 24 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced osteoarthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to June 20, 1967 , that (I) (we) last saw the deceased alive on June 20, 1967 , and that death occurred at 12:30 P.M. from causes and on the date stated above							
22a. SIGNATURE W.R. Cadle		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6-20-67			
22c. PHYSICIAN'S NAME (Type) W. R. Cadle		22d. ADDRESS Emmitsburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Keyville Cemetery		23d. LOCATION (City or Town) (County) (State) Keyville, Md. Carroll Co.	
24. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR JUN 23 1967		25b. REGISTRAR'S SIGNATURE Michaela Judge	

FOR STATE HEALTH DEPT.

08160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08146

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c LENGTH OF STAY IN 1b days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d STREET ADDRESS 200 Thomas Avenue	
3 NAME OF DECEASED (Type or print) CLARA First MYRTLE Middle GREENWALD Last		4 DATE OF DEATH Month June , Day 3 , Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 17, 1889
9 AGE (In years, months, and days) 78 yrs		10 UNDER 1 YEAR Months 10 , Days 1	11 UNDER 24 HRS Hours 19 , Min 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY None	11 BIRTHPLACE (State or foreign country) Feagaville, Maryland
12 CITIZEN OF WHAT COUNTRY U.S.A.		13 FATHER'S NAME James Greenwald	
14 MOTHER'S MAIDEN NAME Mary Measel		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 220-30-9759		17 INFORMANT Address Fred. Miss Nora Jane Deater 200 Thomas Ave. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchopneumonia DUE TO (b) Acute Cerebral Infarction DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed Cerebral Infarct - Epilepsy - Fractured Hip			
20a EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTR. BLTNG. CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home	
20c TIME OF INJURY Month, Day, Year Hour 5 o.m. 28 p.m. 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) Frederick		(County) Frederick	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		22. DATE SIGNED 6-3-67	
EXAMINER'S NAME (Type) Robert J. Thomas		M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6-6-1967	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d LOCATION (City or town) (County) (State) Frederick, Maryland
24 FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland	25a RECEIVED BY REGISTRAR DATE JUN 6 1967
		25b REGISTRAR'S SIGNATURE Charles Judge	



08161

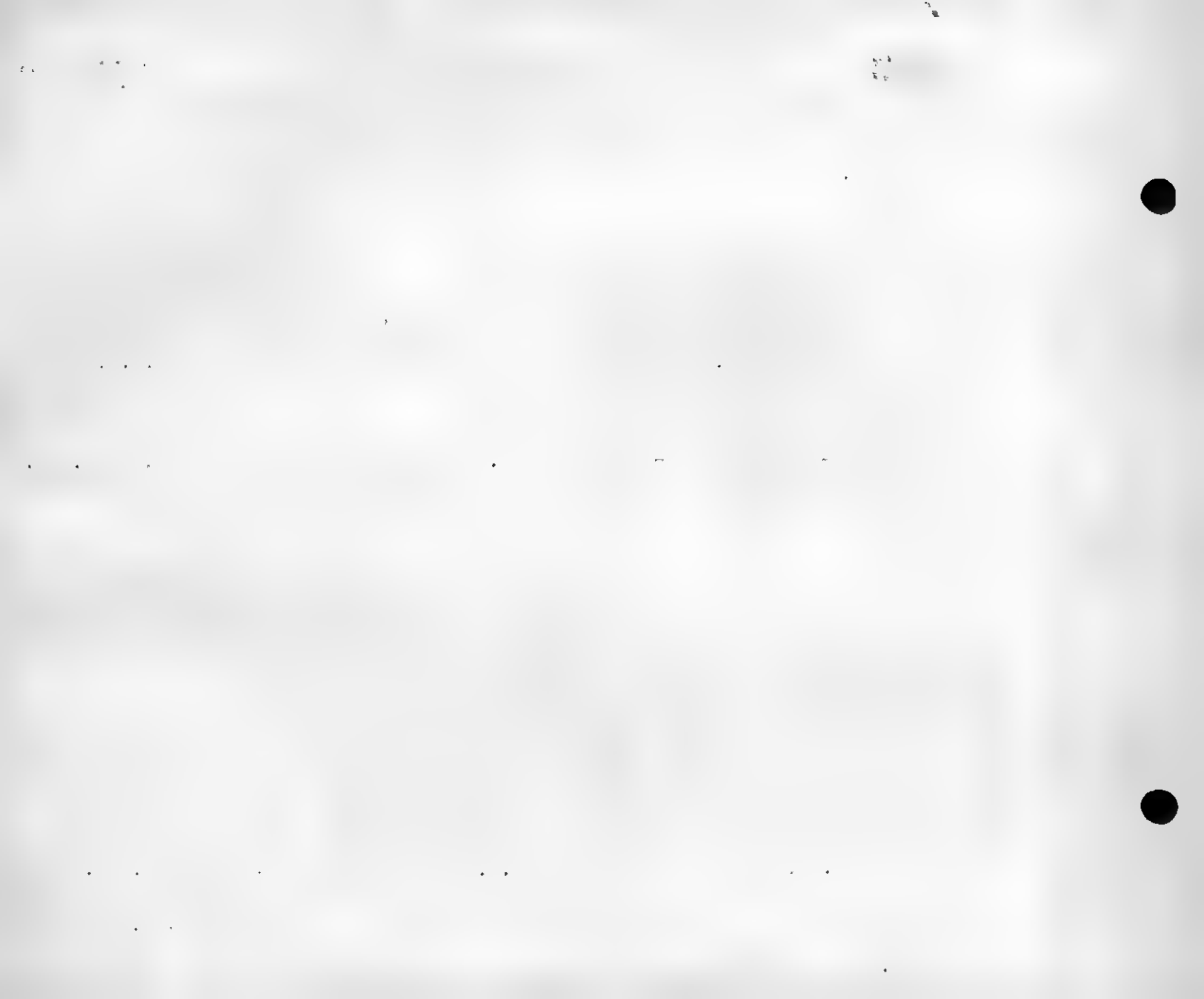
CERTIFICATE OF DEATH

08147

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb 3 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 617 Biggs Avenue		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE XXXXX North Carolina b. COUNTY XXXXX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elizabeth City d. STREET ADDRESS e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph John Harrell		4. DATE OF DEATH Month June Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1900
9. AGE (in years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 24 Days 24 Hrs 19 Mins 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Insurance Rep.		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (County & State, or foreign country) Speed, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph John Harrell		14. MOTHER'S MAIDEN NAME Deborah Harrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 241-28-3795	
17. INFORMANT Mrs. Richard Kruse		Address 617 Biggs Ave. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 67 , to June 24 19 67 ; that (I) (we) last saw the deceased alive on JUNE 23 , 19 67 , and that death occurred at 1:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE A. Austin Pearre, Jr.		22b. DATE SIGNED 6/24/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre, Jr.		22d. ADDRESS 804 Toll House Avenue Fred. Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify) Removal-Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Memory Gardens Cemetery	23d. LOCATION (City or Town) (County) (State) Elizabeth City, N. Carolina
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

08162

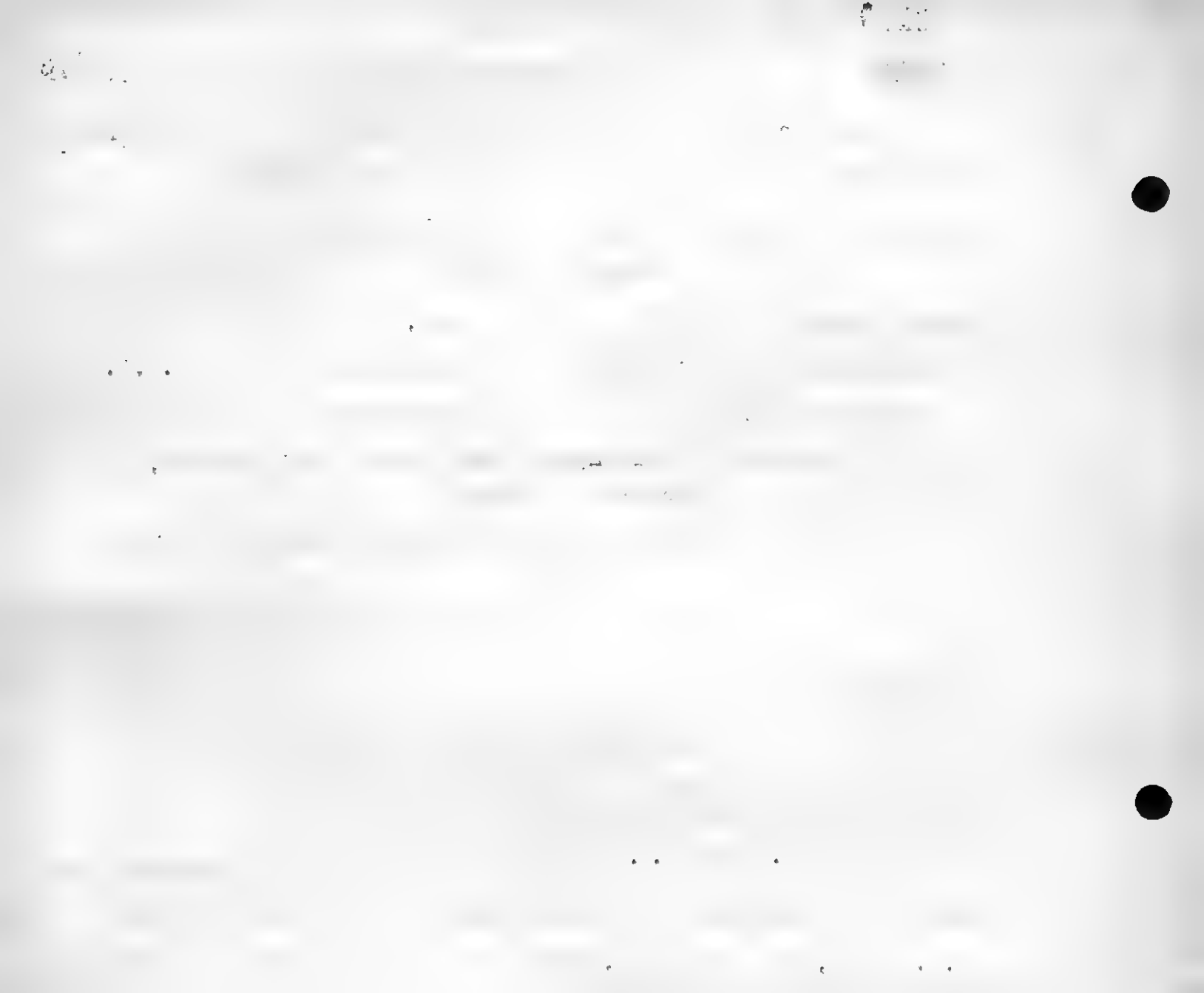
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08148

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mae Ellen Herbert		DATE OF DEATH June 9 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6, 1931
9. AGE (In years, lost birthday) 36 yrs		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks Helper		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Waedon		14. MOTHER'S MAIDEN NAME Effie Naylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-2009028	
17. INFORMANT James Brown		Address Rt 1 Mt Airy, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. NATURE OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas M.D.		22. DATE SIGNED 6/9/67	
EXAMINER'S NAME (Type) Robert J. Thomas M.D.		Address (Street, city, town, or county) Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/13/1967	23c. NAME OF CEMETERY OR CREMATORY St Pauls Church	23d. LOCATION (City or Town) (County) (State) . Della Fred Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Maryland		25a. REC'D BY REG. STRAR JUN 14 1967	
25b. REG. STRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



08163

CERTIFICATE OF DEATH

08149

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>6 wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>9 E. Potomac St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Minnie Himes</u>		4. DATE OF DEATH Month Day Year <u>June 9 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/84</u>
10a. USUAL OCCUPATION (Give kind of work done during 10 years or if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Everitt Alley</u>		14. MOTHER'S MAIDEN NAME <u>Millie (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>216-32-8229</u>	
17. INFORMANT <u>Alma Parsons Brunswick, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>54X Carcinoma of rectum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured right hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>4/20 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Brunswick Fred. Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4/22, 1967</u> , to <u>6/9, 1967</u> that (I) (we) last saw the deceased alive on <u>6/8, 1967</u> and that death occurred at <u>12:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Pilgram</u>		22b. DATE SIGNED <u>6/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Pilgram</u>		22d. ADDRESS <u>Pro 5 Bldg Frederick Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knoxville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Knoxville Md.</u>
24. FUNERAL DIRECTOR <u>Fette Funeral Home</u>		25. REGISTAR'S SIGNATURE <u>Charles J. J...</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08164

CERTIFICATE OF DEATH

08150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Hall Nursing Home		e. STREET ADDRESS 1207 Fairview Avenue	
3. NAME OF DECEASED (Type or print) First Oscar Middle William Last Keyser		4. DATE OF DEATH Month June Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17-1892
9. AGE (In years last birthday) yrs 74		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-		10b. KIND OF BUSINESS OR INDUSTRY Petroleum Distrib-	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Frederick Keyser		14. MOTHER'S MAIDEN NAME Adella E. Stull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214- 10-2472	
17. INFORMANT Mrs. May F. Keyser-1207 Fairview Ave.		Address Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO 12-10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma sigmoid colon DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1 , 19 63 , to June 10 , 19 67 , that (I) (we) last saw the deceased alive on June 9 , 19 67 , and that death occurred on 8 A.M. from causes and on the date stated above.		22b. DATE SIGNED June 10-1967	
22a. SIGNATURE R. S. Thomas		22c. PHYSICIAN'S NAME (Type) Professional Bldg.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Stchison & Son--		25. REG'D BY REGISTRAR June 15 1967	
ADDRESS Frederick, Md. 21701		26. REGISTRAR'S SIGNATURE Charles Judge	

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.

3. The third part is a description of the results
of the study. The results are presented in
the form of tables and graphs. The results
show that the project has been successful in
achieving its objectives. The results are
discussed in detail in the following sections.
4. The fourth part is a discussion of the
implications of the results. The results have
important implications for the field of
study. The results are discussed in detail
in the following sections.

5. The fifth part is a conclusion. The
conclusion is that the project has been
successful in achieving its objectives. The
results have important implications for the
field of study. The results are discussed
in detail in the following sections.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08166

08151

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b HABERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FREDERICK MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CASPER ELLSWORTH KIGHT		4 DATE OF DEATH JUNE 22 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 8, 1926
9 AGE (In years, last birthday) 41 yrs		10 IF UNDER 1 Year Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		12 KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13 BIRTHPLACE (State or foreign country) PIEDMONT W.VA.		14 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 FATHER'S NAME CASPER E. KIGHT		16 MOTHER'S MAIDEN NAME KIRA FRYE	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		18 SOCIAL SECURITY NO WW 2 235-30-0094	
19 INFORMANT THEODORE KIGHT FROSTBURG MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dilated Cardiac Atrium; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Fractured Skull Crushed Chest		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Six car collision		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 8)	
20c TIME OF INJURY Month, Day, Year 2:30 pm 6-22-67		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work Highway	
20e PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) Highway		20f (City or town) (County) (State) Frederick Frederick - Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT J. THOMAS, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 6-22-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a B. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 6/26/67	
23c NAME OF CEMETERY OR CREMATORY PHILLOS CEM. WESTERN PORT. MD		23d LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR W. T. Harrison Hag. Ind		25a REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE		DATE JUN 26 1967	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08152

1 PLACE OF DEATH a COUNTY FREDRICK MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASH.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDRICK		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) HABERSTOWN	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FREDRICK MEMORIAL HOSP.		e STREET ADDRESS 2219 BONNIE BRIAR LANE	
3. NAME OF DECEASED (Type or print) SARAH ELAINE NIGHT		4. DATE OF DEATH JUNE 22 19 67	
5 SEX FM	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 29, 1924 9 AGE (In years last birthday) 42 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN		10b KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
11 BIRTHPLACE (State or foreign country) WESTERN PORT, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. KOOKEN		14. MOTHER'S MAIDEN NAME LAURA BAILEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 220-16-6560	
17 INFORMANT MARY A. SHIREY CUMBERLAND		Address MD.	
18 CAUSE OF DEATH (Enter on y one cause per line (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed Chest, Lacerated Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Fractured Skull (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Six car collision on highway	
20c TIME OF INJURY Month, Day, Year 2:50 pm 6-22-67	20d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f (City or town) (County) (State) W. Frederick - Frederick - Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert D. Thomas		22. DATE SIGNED 6-22-67	
EXAMINER'S NAME (Type) ROBERT D. THOMAS, M.D.		Address (Street, city, town or county)	
23a BURIAL CREMATION BURIAL	23b DATE THEREOF 6/26/67	23c NAME OF CEMETERY OR CREMATORY PHILOPS CEMETERY	23d LOCATION (City or Town) (County) (State) WESTERN PORT MD.
24 FUNERAL DIRECTOR W. T. Harcourt, Hag. Ind.		25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE Charles Judge

JUN 26 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> 081627 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="display: flex; justify-content: space-between;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 08153 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																																			
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 1 West I Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) First Baby Boy Middle King Last King			4. DATE OF DEATH Month 6 Day 23 Year 1967			5. SEX M			6. COLOR OR RACE N			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/23/67			9. AGE (In years last birthday) yrs. 6 Months 23 Days 19 Hours 67 Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) Fred. Co., Md.						12. CITIZEN OF WHAT COUNTRY?																	
13. FATHER'S NAME Mack Arthur Rowe												14. MOTHER'S MAIDEN NAME Shirley King																							
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)												16. SOCIAL SECURITY NO. (If yes give war or dates of service)												17. INFORMANT Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>BW 2 lb 1 1/2 oz</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																								INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>67</u> , to <u>6/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/23</u> , 19 <u>67</u> and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.																																			
22a. SIGNATURE <u>J. Fred Baker</u>												22b. DATE SIGNED <u>6/23/67</u>																							
22c. PHYSICIAN'S NAME (Type) J. FRED BAKER M.D.												22d. ADDRESS Frederick, Md.																							
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>6-24-67</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Col Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Loeville Virginia</u>																	
24. FUNERAL DIRECTOR <u>Leete Funeral Home Brunswick Md</u>												25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																							

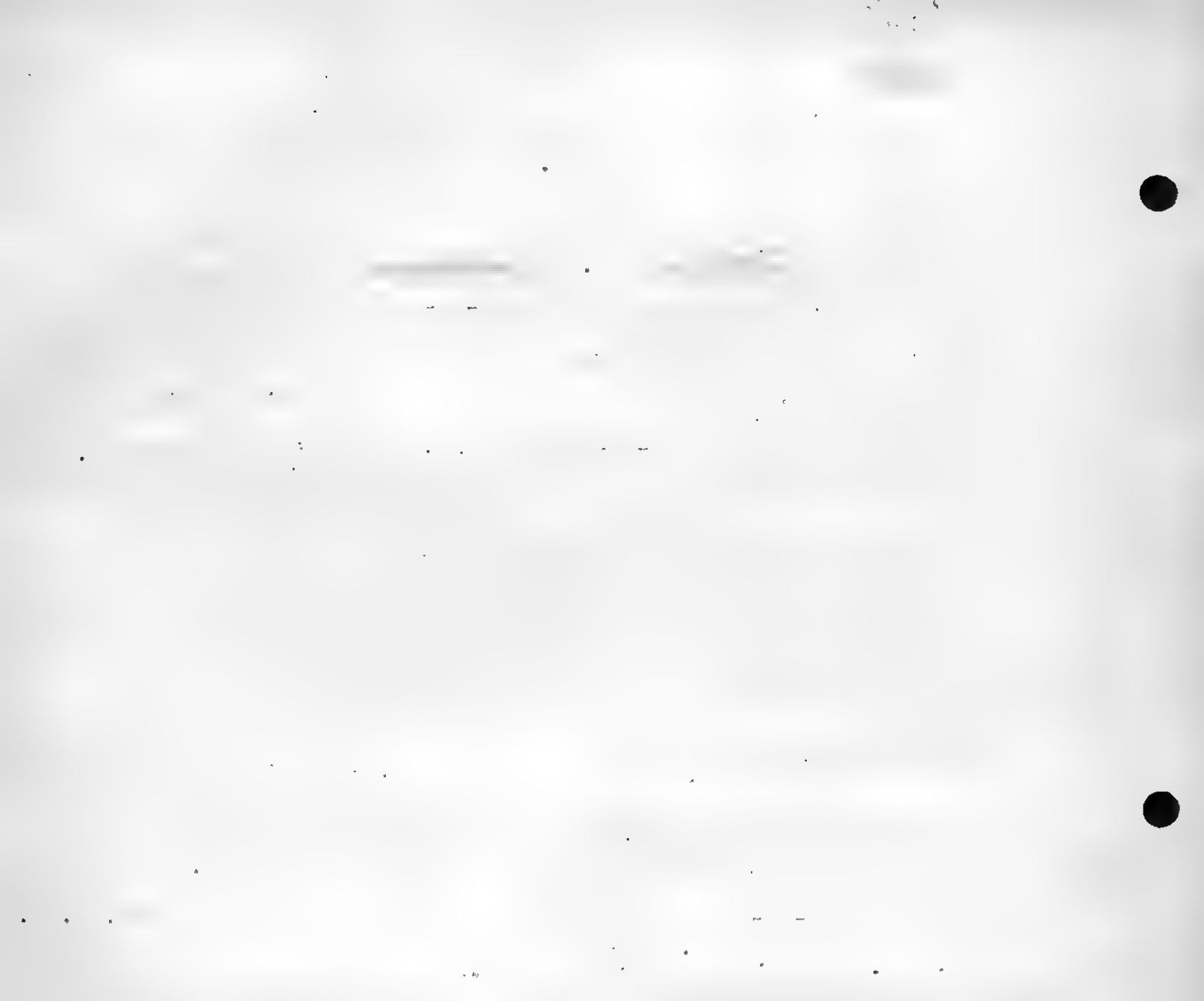
7-194347

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 11 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont rural c. LENGTH OF STAY IN 1b 50 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Own Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont rural d. STREET ADDRESS RD 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ORESTES Middle F. Last LEATHERMAN		4. DATE OF DEATH Month JUNE Day 22 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1878
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Leatherman		14. MOTHER'S MAIDEN NAME Josephine Curtis	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-0048	
17. INFORMANT John D. Leatherman		Address Thurmont Md. RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arterio-sclerotic heart di DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 10+ yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 17 June 1967 , to 22 June 1967 , that (I) (we) last saw the deceased alive on 17 June 1967 , and that death occurred at 255 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr.		22b. DATE SIGNED 22 JUNE 1967	
22c. PHYSICIAN'S NAME (Type) CHARLES H. CONLEY, JR.		22d. ADDRESS Professional Bldg. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-25-67	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	23d. LOCATION (City, town or county) (State) Thurmont Fred. Co. Md.
24. FUNERAL DIRECTOR Raymond E. Greger		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1967	



08163

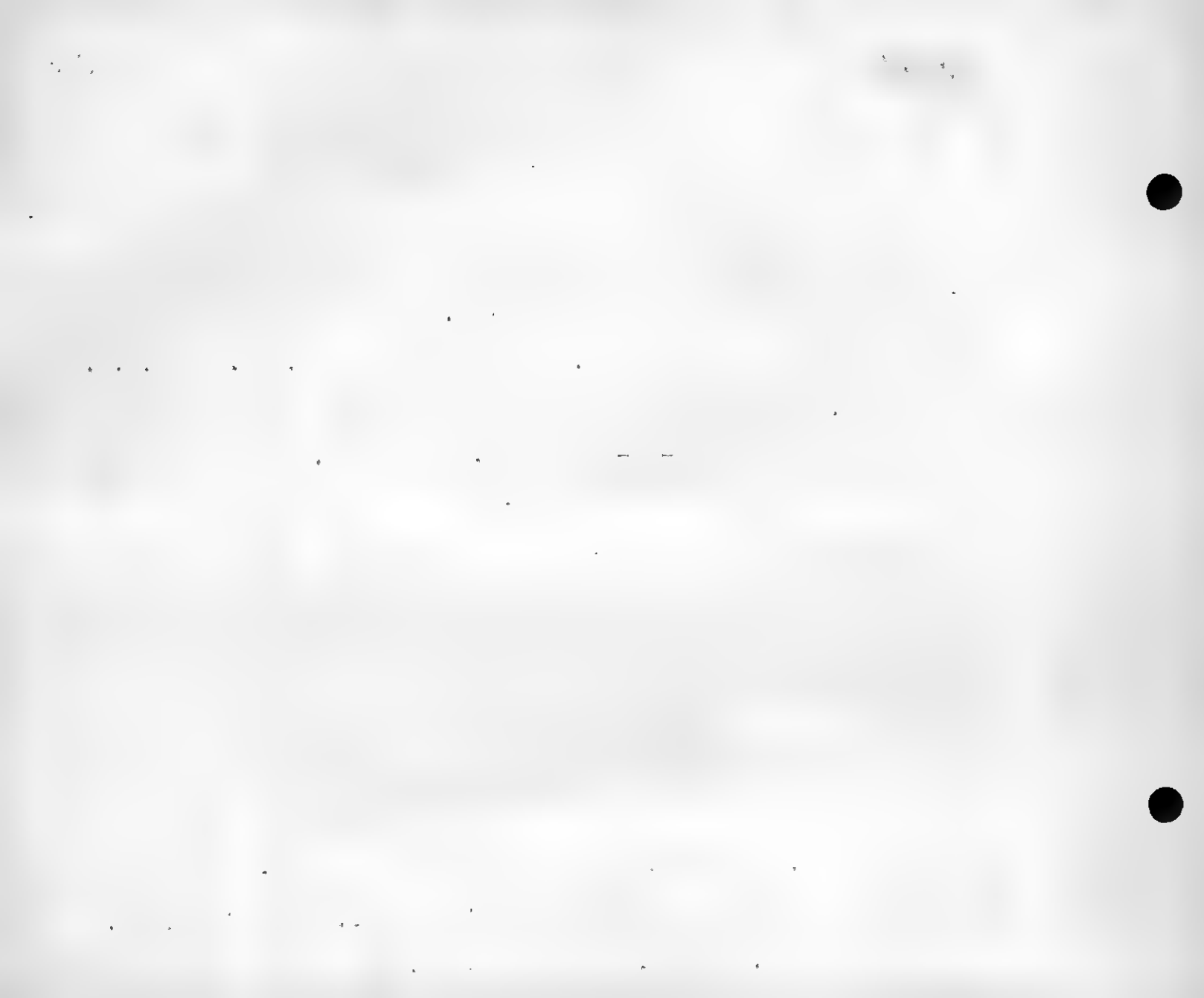
CERTIFICATE OF DEATH

08155

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c LENGTH OF STAY in 1b 50 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last VERNON WARD LEATHERMAN		4. DATE OF DEATH Month Day Year June 28, 1967	
5 SEX male white	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1874
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR IND. STRY own gen. farm	
11 BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John C. Leatherman		14. MOTHER'S MAIDEN NAME Susan Grossnickle	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 212-50-9971	
17 INFORMANT Mrs. Margaret N. Dutrow, Myersville, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO (b) Generalized Arterio-Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 6, 1967 , to June 28, 1967 , that (I) (we) last saw the deceased alive on June 24, 1967 , and that death occurred at 6 M. from causes and on the date stated above.			
22a. SIGNATURE J. Elmer Harp		22b. DATE SIGNED 6-30-67	
22c. PHYSICIAN'S NAME (Type) J. Elmer Harp		22d. ADDRESS Middletown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Grossnickle's		23d. LOCATION (City or Town) (County) (State) Nr. Myersville, Md.	
24. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md		25a. REC'D BY REGISTRAR JUL 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08170

CERTIFICATE OF DEATH

08156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Knoxville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leoma Frederick Lincks		4. DATE OF DEATH Month 6 Day 29 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1899
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 29 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis H. Lincks		14. MOTHER'S MAIDEN NAME Loyetta Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-05-6955	
17. INFORMANT Thurston Lincks		Address Knoxville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO (b) Angina pectoris DUE TO (c) Angina pectoris Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Jaundice, hepatomegaly		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/26/67 , 19 to 6/29/67 , 19, that (I) (we) last saw the deceased alive on 6/29/67 , 19, and that death occurred at 4:38 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. Austin Pearre		22b. DATE SIGNED 6/29/67	
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, M.D.		22d. ADDRESS Frederick Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 7/1/67	23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery Brunswick Maryland	23d. LOCATION (City or Town) (County) (State) Brunswick Maryland
24. FUNERAL DIRECTOR Leota Funeral Home		25. REGISTRAR'S SIGNATURE Charles Judge	

08171

CERTIFICATE OF DEATH

08157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick New Addition		c LENGTH OF STAY IN 1b Brunswick	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) New Addition		d STREET ADDRESS 733 East Potomac Street	
3 NAME OF DECEASED (Type or print) Arrah Mae Lloyd		4. DATE OF DEATH Month 6 Day 3 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/04
9 AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Careteria cook (Elementary School)		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11 BIRTHPLACE (County & State, or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Wilt		14. MOTHER'S MAIDEN NAME Lizzie Frye	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-34-2284	
17 INFORMANT James M. Lloyd, Falling Water, W.Va.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma - rt. breast DUE TO (b) generalized metastases DUE TO (c) 170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 6-3-1967 , that (I) (we) last saw the deceased alive on 6-3-1967 , and that death occurred at AT M, from causes and on the date stated above.			
22a. SIGNATURE Charles E. Pruitt, M.D.		22b. DATE SIGNED 6-5-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Brunswick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/6/67	
23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery		23d. LOCATION (City or town) (County) (State) Brunswick Maryland	
24. FUNERAL DIRECTOR Feeter Funeral Home - Brunswick Md		25a. REC'D BY REGISTRAR JUN 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Figure 1

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08172

CERTIFICATE OF DEATH

08158

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b Since 1963 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Md. Odd Fellows Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2909 Dunran Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle H. Last Louden		4. DATE OF DEATH Month June Day 27- Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18-1887
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Laura Burley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-07-9116D	
17. INFORMANT Md. Odd Fellows Home-		Address Frederick, Md. 21701	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arterio sclerosis (generalized) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ----- (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		INTERVAL BETWEEN ONSET AND DEATH 1 Month 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from June 26, 1967 to June 27, 1967 , that (I) (we) last saw the deceased alive on June 26, 1967 , and that death occurred at 12:05A from the causes and on the date stated above.			
22a. SIGNATURE Dr. B.O. Thomas, Jr.		22b. DATE SIGNED June 27-67	
22c. PHYSICIAN'S NAME (Type) Dr. B.O. Thomas, Jr.		22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 30-1967	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION (City, town or county) (State) Baltimore- Md.
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Fitchison & Son		25a. REC'D BY REGISTRAR June 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

F.R. Zischgen & Son Frederick, Md. 21031

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08173

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08159

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DQA- Frederick Memorial Hospital			d. STREET ADDRESS 227 E. 4th. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wm. Graden Markoe			4. DATE OF DEATH Month June Day 6- Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14-1908	9. AGE (In years last birthday) 58 yrs	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Tailoring Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Wm. G. Markoe		
14. MOTHER'S MAIDEN NAME Ada Baker			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO 214-10-3061		17. INFORMANT Miss Betty Lou Markoe-227 E. 4th. St.-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Coronary artery occlusion DUE TO (c) Arteriosclerotic cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED June 6-1967	
EXAMINER'S NAME (Type) Dr. Robert J. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23e. REC'D BY REGISTRAR Charles Judge		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Frederick, Md.		DATE JUN 14 1967	

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08174

CERTIFICATE OF DEATH

08160

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland COUNTY Fred rick	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS RD 1	
3. NAME OF DECEASED (Type or print) Lessie Daisey Martin		4. DATE OF DEATH Month June Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-1884
9. AGE (In years and birthday) 83 yrs		10. IF UNDER 1 YEAR Months 03 Days 01 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Shuff		14. MOTHER'S MAIDEN NAME Matilda Mumford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-03-4017A	
17. INFORMANT Mrs. Clara Fuss Thurmont, Md.		Address RD1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart disease, arteriosclerotic type DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1 , 19 63 , to June 16 , 19 67 , that (I) (we) last saw the deceased alive on June 16 , 19 67 , and that death occurred at 12:30 A from causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-67	
23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		23d. LOCATION (City or Town) (County) (State) Lewistown Md. Fred. Co.	
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR Raymond E. Creager	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 22 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08175.

CERTIFICATE OF DEATH

08161

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Important:** Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Knoxville)		c. LENGTH OF STAY IN 1b Rural (Knoxville)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) CHARLES FRANCIS MATHEWS		4. DATE OF DEATH Month 6 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/88
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 10 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired employee B&O R.R.		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (County & State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Branson Mathews		14. MOTHER'S MAIDEN NAME Mary Redickor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-0544	
17. INFORMANT Pearl Ella Mathews		Address Knoxville, Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost chronic (b) arteriosclerosis (c) 20yr			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 6-6-1967 , that (I) (we) last saw the deceased alive on 6-5-1967 , and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE C.E. Pruitt, M.D.		22b. DATE SIGNED 6-5-67	
22c. PHYSICIAN'S NAME (Type) C.E. Pruitt, M.D.		22d. ADDRESS Brunswick Maryland	
23a. BURIAL, CREMATION, REMOVAL, etc. burial	23b. DATE THEREOF 6/10/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Church Cemetery	23d. LOCATION (City or Town) (County) (State) Garrotts Mill Md.
24. FUNERAL DIRECTOR Leete Funeral Home		25a. REC'D BY REGISTRAR DATE JUN 12 1967	
ADDRESS Brunswick Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department of Frederick prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

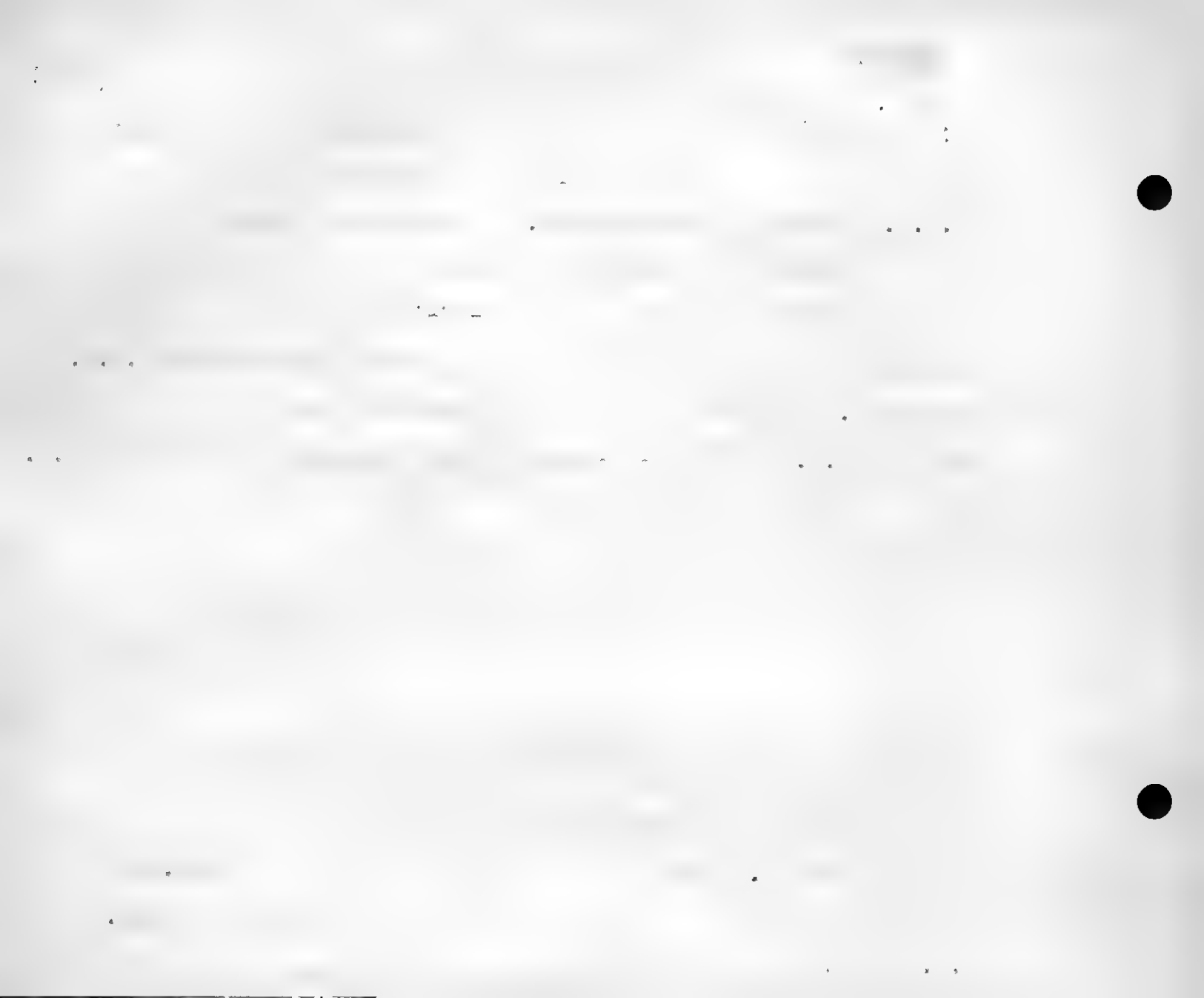
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08176

08162

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 14 years		d. STREET ADDRESS 316 Madison Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Frederick Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) James Lawrence McCloud		4 DATE OF DEATH Month June Day 27 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-26-1921
9 AGE (In years last birthday) 45 yrs		10 IF UNDER 1 YEAR Months 19 Days 67 Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks Helper		10b KIND OF BUSINESS OR INDUSTRY *****	
11 BIRTHPLACE (State or foreign country) District of Columbia U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles D. McCloud		14. MOTHER'S MAIDEN NAME Isabelle Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16. SOC. SEC. NO. 578-20-1483	
17. INFORMANT Charles McCloud		Address Washington D C 502 25th Place N.E.C	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 161X Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Bronchitis (c) Carcinoma of Larynx		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) Robert J. Thomas		22. DATE SIGNED 6-27-67 Fred. Ma	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/67	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Frederick Fred. Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md		25a. RECORDING SIGNATURE Charles Judge DATE JUN 29 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08177

CERTIFICATE OF DEATH

08168

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Week d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 104 Carroll Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES H. MERCER		4 DATE OF DEATH Month June Day 5 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 22, 1892
9 AGE (in years last birthday) 74 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Petroleum Business
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Charles E. Mercer		14 MOTHER'S MAIDEN NAME Lavinia Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218 30 9333A	
17 INFORMANT Mrs. Cora Mercer (Same as item # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Dis DUE TO (c) 3 years Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 3, 1967 to June 5, 1967 , that (I) (we) last saw the deceased alive on June 5, 1967 , and that death occurred at 8:11 A M, from causes and on the date stated above.			
22a. SIGNATURE Thomas E. Stone		22b. DATE SIGNED June 6, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.		22d. ADDRESS 4 West Third Street, Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR H. R. Stetson & Son, Frederick, Maryland		25. REC'D BY REGISTRAR MIN 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

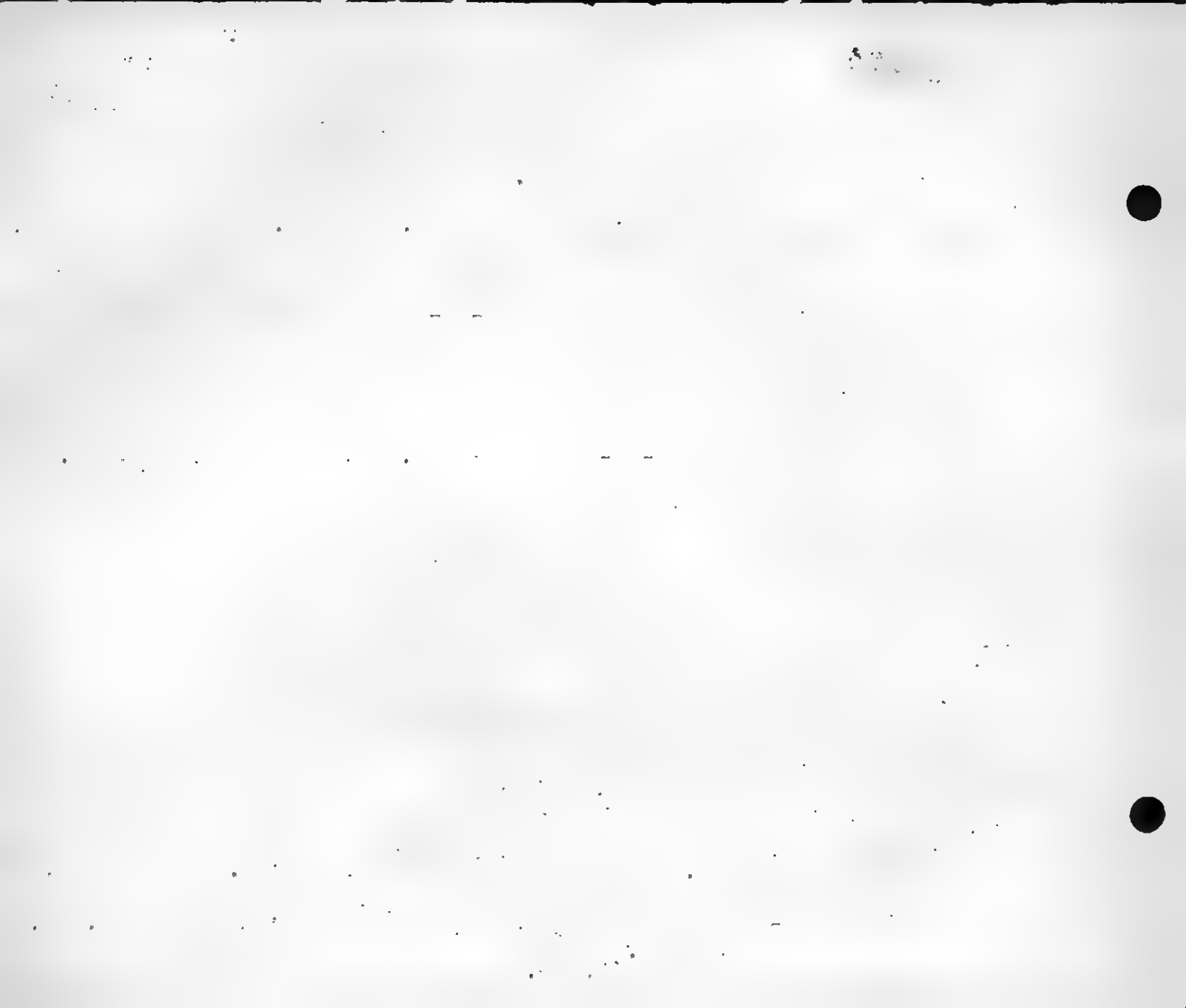
08173

08154

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN ID <u>16 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wynelle Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> d. STREET ADDRESS <u>W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Alice</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1967</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-1875</u>		9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Abdiel Garber</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-52-2195</u>		17. INFORMANT <u>Harry O. Miller</u>		Address <u>Thurmont, Md. RD2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>E CONGESTIVE HEART FAILURE</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>2/5</u> , 19 <u>66</u> , to <u>6/12</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/22</u> 19 <u>67</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard C. Reynolds</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/13/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds</u>						22d. ADDRESS <u>Toll House Ave. Fredrick, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Thurmont Fred Co. Md.</u>							
24. FUNERAL DIRECTOR <u>Raymond E. Creager</u>						ADDRESS <u>Thurmont, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08173

08165

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 205 East 'A' Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital							
3. NAME OF DECEASED (Type or print) OLIVER		First		Middle CHARLES		Last MYERS	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH JUNE 19 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer B&O Railroad		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 72 yrs.		11. BIRTHPLACE (County & State, or foreign country) Samuels Manor Maryland	
13. FATHER'S NAME Asher Myers		16. SOCIAL SECURITY NO. 719-03-1862		17. INFORMANT Florence Hoffmaster		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 719-03-1862		17. INFORMANT Florence Hoffmaster		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH One hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19 1967 , to 6/19 1967 , that (I) (we) last saw the deceased alive on 6/19 1967 , and that death occurred at 12:03 AM , from the causes and on the date stated above.							
22a. SIGNATURE Richard C. Reynolds				22b. DATE SIGNED 6/19/67		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D.				22d. ADDRESS 804 Toll House Ave. Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/67		23c. NAME OF CEMETERY OR CREMATORY Samuels Manor Cemetery		23d. LOCATION (City, town or county) (State) Samuels Manor Md.	
24. FUNERAL DIRECTOR Leete Funeral Home				25a. REC'D BY REGISTRAR JUN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

08180

CERTIFICATE OF DEATH

08166

1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Doubs</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>Box 53- Doubs</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>More</u> Last <u>Philmore Newman, Jr</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-3-1898</u>		9 AGE (In years last birthday) <u>68</u> yrs	10 IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Philmore Newman, Sr</u>				14. MOTHER'S MAIDEN NAME <u>CORA WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-12-7161</u>		17. INFORMANT <u>EARL F. NEWMAN</u>		Address <u>York-Pa 712 Jessop Place</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>2-3 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of liver</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>67</u> , to <u>June 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Henry V. Chase</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				22d. ADDRESS <u>804 Toll House Ave Frederick, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-9-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANT PLEASANT Church</u>		23d. LOCATION (City or Town) (County) (State) <u>LUCKETTS VA</u>	
24. FUNERAL DIRECTOR <u>C.F. HICKS III</u>				ADDRESS <u>Frederick, Md</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08181

CERTIFICATE OF DEATH

08167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY - Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Tenn. b. COUNTY Blount	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Mem. Hospital		d. STREET ADDRESS 214 Stanley St.	
3 NAME OF DECEASED (Type or print) Thomas Lamar Nuchols		4 DATE OF DEATH Month June Day 19 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 20, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Banker		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 91 yrs
11 BIRTHPLACE (County & State, or foreign country) Maryville, Tenn.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Waters Nuchols		14. MOTHER'S MAIDEN NAME Mary Jane Broady	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 409-05-9797	
17. INFORMANT Mr. James W. Hitch, Damascus, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CONGESTIVE HEART FAILURE + PUL. EDEMA DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CARCINOMA PROSTATE, CARCINOMA BLADDER, ART. SCL. GENERALIZED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/25, 1967 , to 6/19, 1967 , that (I) (we) last saw the deceased alive on 6/15, 1967 , and that death occurred at 7:05 P.M. from causes and on the date stated above			
22a. SIGNATURE GILGIN F. McADAMS, M.D.		22b. DATE SIGNED 6/19/67	
22c. PHYSICIAN'S NAME (Type) GILGIN F. McADAMS, M.D.		22d. ADDRESS 610 TOLL HOUSE AVE FREDERICK, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Baptist	23d. LOCATION (City or Town) (County) (State) Maryville, Tenn.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR JUN 21 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08182

CERTIFICATE OF DEATH

08169

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural c. LENGTH OF STAY IN 1b 35 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 5		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick d. STREET ADDRESS Route 5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Fannie G. Phleeeger		4. DATE OF DEATH Month Day Year 6 27 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/27/1867
9 AGE (In years last birthday) 99 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Henry Gonso	
14. MOTHER'S MAIDEN NAME Charlotte Kolb		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 219-54-2312		17 INFORMANT Ida Phleeeger, Frederick, Md.	
18 ADDRESS Route 5		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18b CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure DUE TO (b) Cardiogenic heart disease DUE TO (c) 5 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to Oct. 1967 , that (I) (we) last saw the deceased alive on 5/22 1967 , and that death occurred at 1:54 PM , from causes and on the date stated above.			
22a SIGNATURE James B. Thomas		22b DATE SIGNED 6/29/67	
22c PHYSICIAN'S NAME (Type) Dr. James B. Thomas		22d ADDRESS Frederick, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 6/29/67	23c NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d LOCATION (City or Town) (County) (State) Middletown, Fred., MD.
24 FUNERAL DIRECTOR ADDRESS Gladhill Company, Middletown, Md.		25a REC'D BY REGISTRAR JUL 3 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08183

CERTIFICATE OF DEATH

08168

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 N. Maryland Ave.		d. STREET ADDRESS same	
3. NAME OF DECEASED (Type or print) Marie Margaret Rau		4. DATE OF DEATH Month 6 Day 15 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/96
9 AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 15 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Harpers Ferry W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Leo Bowler		14. MOTHER'S MAIDEN NAME Margaret Kain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Mary Agnes Willey		Address Baltimore Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 6-1-1967 to 6-15-1967 , that (1) (we) last saw the deceased alive on 6-15-1967 , and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert J. Thomas		22b. DATE SIGNED 6/16/67	
22c. PHYSICIAN'S NAME (Type) ROBERT J. THOMAS M.D.		22d. ADDRESS 812 JOE HOUSE CIRC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/19/67	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City or Town) (County) (State) Harpers Ferry W. VA.
24. FUNERAL DIRECTOR Heete Funeral Home		25a. REC'D BY REGISTRAR JUN 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08184

08170

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg d. STREET ADDRESS Middleburg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg, Md. FREDERICK		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wd 200, WRGH, Ft Detrick, Md.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH A. ROSEBROCK		4. DATE OF DEATH June 22 1967	
5. SEX Male		6. COLOR OR RACE Cauc	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 4, 1922	
9. AGE (In years If UNDER 1 YEAR If UNDER 24 HRS. last birthday) 45 yrs.		10. BIRTHPLACE (County & State, or foreign country) Queens, New York	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Rosebrock		14. MOTHER'S MAIDEN NAME Emma Sassa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1942 - 1965		16. SOCIAL SECURITY NO. 066 16 6398	
17. INFORMANT Jane G. Rosebrock		Address Wife Middleburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 11 Hour a.m. June 22, 1967			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smith's Bakery			
20f. (City or town) Ladiesburg (County) Frederick (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 22 June 1967 to 22 June 1967 , that (I) (we) last saw the deceased alive on 22 June 1967 , and that death occurred at 13:20 , from the causes and on the date stated above.			
22a. SIGNATURE A. C. Alevizatos			
22b. DATE SIGNED 22 June 67			
22c. PHYSICIAN'S NAME (Type) A. C. ALEVIZATOS, -Captain, MC-			
22d. ADDRESS US Army Medical Unit, Ft Detrick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF June 26 '67			
23c. NAME OF CEMETERY OR CREMATORY Middleburg Cemetery			
23d. LOCATION (City, town or county) Middleburg, Carroll Co. Md. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr., Prostomate, Md. 2/15/7			
25a. RECORD BY REGISTRAR JUN 26 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08185

CERTIFICATE OF DEATH

08171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Rural (Knoxville)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Nursing Home		d. STREET ADDRESS Box 57-Route 2	
3 NAME OF DECEASED (Type or print) Beulah M. Sanger		4 DATE OF DEATH Month 6 Day II Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/1/93
9 AGE (In years last birthday) yrs 74		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Purcellville Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest F. Fletcher	
14 MOTHER'S MAIDEN NAME Orra Belle Shoemaker		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO 414-32-4195		17 INFORMANT Charles E. Sanger Address Knoxville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac vascular accident 3-1-7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 11, 1966 to June 11, 1967 that (I) (we) last saw the deceased alive on June 11, 1967 and that death occurred at 3:28 PM from causes and on the date stated above.			
22a. SIGNATURE Le Roy Davis		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL CREMATION, REMAINS REMOVED	23b DATE THEREOF 6/13/67	23c NAME OF CEMETERY OR CREMATORY Lake View Cemetery	23d LOCATION (City or town) (County) (State) Hamilton Virginia
24 FUNERAL DIRECTOR Teete Funeral Home		25a REC'D BY REGISTRAR 15 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
20 M 1/66

08186

CERTIFICATE OF DEATH

08172

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home		d. STREET ADDRESS 910 Chestnut Street	
3 NAME OF DECEASED (Type or print) GRACE L. SCHAFER		4 DATE OF DEATH Month June Day 7 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 7, 1889
9 AGE (In years last birthday) 78 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Frederick County, Maryland	
12 CITIZENSHIP OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward Zimmerman	
14. MOTHER'S MAIDEN NAME Amanda M. Staley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 215 36 6826 D		17. INFORMANT Address Frederick, Md. Mrs. John A. Summers, Route #5,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Crownary artery disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour year 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April, 1963 , to 6/7, 1967 that (I) (we) last saw the deceased alive on 6/3, 1967 and that death occurred at 6 A M, from causes and on the date stated above.			
22a. SIGNATURE James B. Thomas		22b. DATE SIGNED June 8, 1967	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St. Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24 FUNERAL DIRECTOR M. R. Stchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR JUN 14 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			



08187

CERTIFICATE OF DEATH

08173

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Booke R.F.D.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Booke Rural</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARVEY THEODORE SCHWARTZBECK</u>		4. DATE OF DEATH <u>June 6 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 16 1916</u>
9. AGE (In years last birthday) <u>51</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. US. OCCUPATION (Give kind of work done during most of working life; even if retired) <u>House Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Contractor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Schwartzbeck</u>		14. MOTHER'S M maiden name <u>Mary Custer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>578-05-9610</u>	
17. INFORMANT <u>Mrs. Carolyn Schwartzbeck</u>		Address <u>Booke Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>yes</u>		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1964</u> , 19 <u>66</u> , to <u>May</u> , 19 <u>67</u> that (I) (<u>we</u>) last saw the deceased alive on <u>5/24</u> 19 <u>67</u> , and that death occurred at <u>5:12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J.R. Poirier</u> M.D.		22b. DATE SIGNED <u>6/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.R. POIRIER M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		23d. LOCATION (City or Town) (County) (State) <u>Point of Rocks Fred. Md.</u>	
24. FUNERAL DIRECTOR <u>Constance C. Hilton</u>		25a. REC'D BY REGISTRAR <u>Barneville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 12 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08174

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c LENGTH OF STAY N 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 South Market Street		d. STREET ADDRESS 5 South Market Street	
3 NAME OF DECEASED (Type or print) First Middle Last Allen Melvin Seeger, Sr.		4 DATE OF DEATH Month Day Year June 27 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16, 1901
9. AGE (In years last birthday) yrs 65		10 IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b KIND OF BUSINESS OR INDUSTRY Hardware Company	
11 BIRTHPLACE (State or foreign country) Frederick, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles F. Seeger		14 MOTHER'S MAIDEN NAME Marguerite Michael	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv. etc.) Yes W.W.# 2		16 SOCIAL SECURITY NO 214 10 1600	
17 INFORMANT A. Melvin Seeger, Jr.		Address 105 East 4th. Street Frederick, Maryland	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive HEART Failure DUE TO (b) CORONARY ARTERY Occlusion - Myocardial Infarction DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR Disease (Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert J. Thomas, M. D.		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF June 29, 1967	
23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Frederick, Maryland	
24 FUNERAL DIRECTOR Douglas M. Fadelley		25a REC'D BY REGISTRAR June 30 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c ADDRESS M. R. Etchison & Son, Frederick, Maryland	

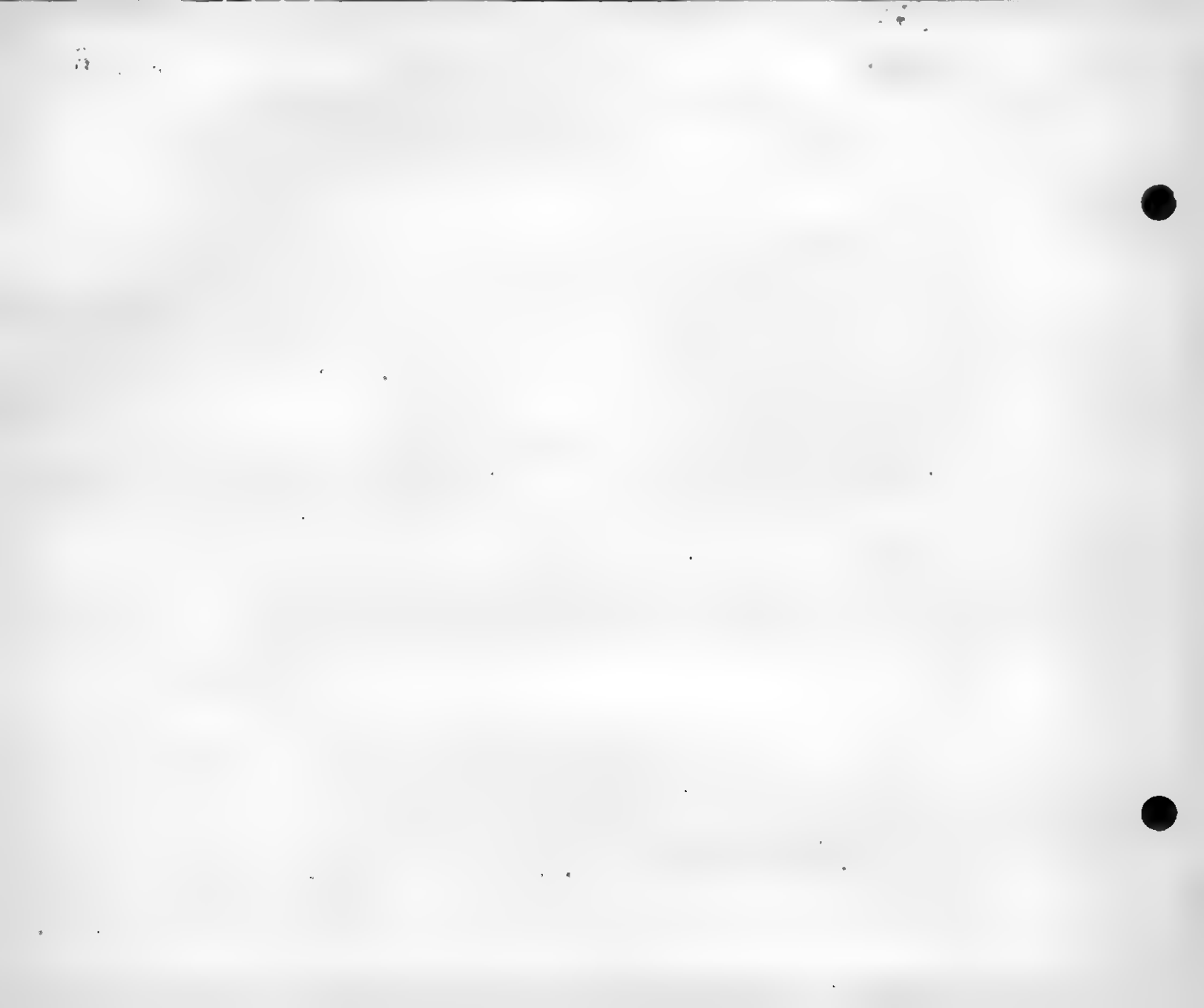
08189

CERTIFICATE OF DEATH

08175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carroll Middle Joseph Last Shelton				4. DATE OF DEATH Month June Day 21 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1903		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 21 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Fred. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James William Shelton				14. MOTHER'S MAIDEN NAME Estella Mc Kinney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-14-2850		17. INFORMANT Mr. Raymond Shelton, Emmitsburg, Md. R # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Massive Coronary Occlusion DUE TO (b) Coronary Insufficiency DUE TO (c) Arteriosclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 10 min 7 yrs 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema, Low Grade Heart						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 59 , to 6/21 , 19 67 , that (I) (the hospital) saw the deceased alive on 6/20 , 19 67 , and that death occurred at 12:00 M, from causes and on the date stated above.							
22a. SIGNATURE E. Ambler Thompson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/22/67	
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson, M.D.				22d. ADDRESS Taneytown, Maryland			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery		23d. LOCATION (City or Town) (County) (State) Ladiesburg, Frederick, Md.	
24. FUNERAL DIRECTOR John M. Skiles C.O. Fuss & Son				ADDRESS Taneytown, Md.		25a. REC'D BY REGISTRAR June 26, 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



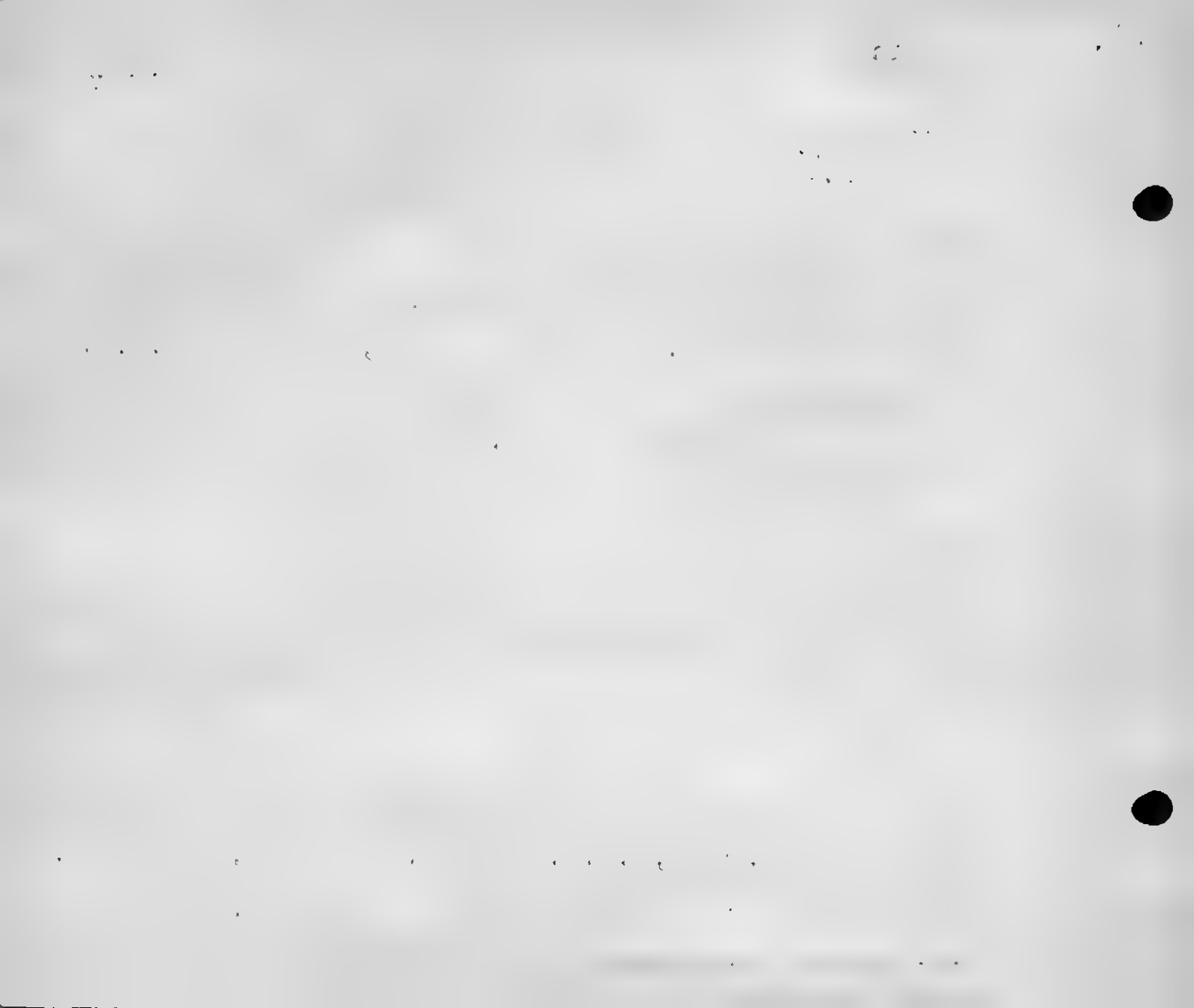
08190

CERTIFICATE OF DEATH

08176

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 204 Maple Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 204 Maple Avenue			
3. NAME OF DECEASED (Type or print) RENO OSBORNE SIX				4. DATE OF DEATH Month June Day 21 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1905	
9. AGE (In years last birthday) 61 yrs		10. UNDER 1 YEAR Months 0 Days 0		11. UNDER 24 HRS Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Fred. City Policeman			
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Osborne Six				14. MOTHER'S MAIDEN NAME Mamie Boone			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Agnes Six, (Same as item # 2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio-sclerotic CVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 minutes 2 years.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1965 to June 21, 1967 , that (I) (we) last saw the deceased alive on June 20, 1967 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard O. Thomas, Jr.				22b. DATE SIGNED June 22, 1967			
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr. M. D.				22d. ADDRESS 228 N. Market Street, Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE JUN 26 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08191

CERTIFICATE OF DEATH

08177

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz		c. LENGTH OF STAY in lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS Lantz	
3. NAME OF DECEASED (Type or print) First William Albert Middle Smith Last		4. DATE OF DEATH Month June Day 18 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1883
9. AGE (In years last birthday) yrs 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Camelia Buhrman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-3970	
17. INFORMANT Edith L. Smith		Address Lantz, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3-4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-5 , 19 67 , to 18 June, 1967 , that (I) (we) lost saw the deceased alive on 17 June 1967 , and that death occurred at 4:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Harry H. Youngs M.D.		22b. DATE SIGNED 6-19-67	
22c. PHYSICIAN'S NAME (Type) Harry H. Youngs		22d. ADDRESS Blue Ridge Summit, Pa.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-21-67	23c. NAME OF CEMETERY OR CREMATORY Bethel Ch. of God	23d. LOCATION (City or Town) (County) (State) Germantown, Md.
24. BURIAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR JUN 22 1967	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08192					08178				
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY in 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 277 W. 5th. St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elsie First Marie Middle Solt Last			4. DATE OF DEATH June Month 24- Day 1967 Year						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8- 1909	9. AGE (in years last birthday) 57 yrs.	10. UNDER 1 YEAR Months 5	11. UNDER 24 HRS. Days 2	12. HOURS 10	13. MIN. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Hosp. Diet Kitchen		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Elmer Solt				14. MOTHER'S MAIDEN NAME Bertie L. Haller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-38-1251		17. INFORMANT Mrs. Myrtis S. Albaugh-277 W. 5th. St.- Address Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma Body + Tail DUE TO (c) of Pancreas								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick (County) Frederick (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 1957 , to 6/24 , 19 67 , that (I) (we) last saw the deceased alive on 6/24 , 19 67 , and that death occurred at 6:00 M., from the causes and on the date stated above.									
22a. SIGNATURE James B. Thomas 22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701		22b. DATE SIGNED 6-25-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 27-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701 (State) Md.			
24. FUNERAL DIRECTOR M.R. Etchison & Son Address Frederick, Md. 21701				25a. REC'D BY REGISTRAR Charles Judge DATE JUN 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

No 21701
 Prop. Miss. - Frederick, No. 21701
 L. James F. Thomas
 Mrs. Martin S. Alden - 21701
 James F. Alden
 Helmer
 Female White
 X
 27 Aug. - 1919
 June 24- 07
 277 N. 5th St.
 Frederick
 Lifetime
 Frederick Memorial Hospital
 Marie
 201
 277 N. 5th St.

Frederick, No. 21701
 Prop. Miss. - Frederick, No. 21701
 L. James F. Thomas
 Mrs. Martin S. Alden - 21701
 James F. Alden
 Helmer
 Female White
 X
 27 Aug. - 1919
 June 24- 07
 277 N. 5th St.
 Frederick
 Lifetime
 Frederick Memorial Hospital
 Marie
 201
 277 N. 5th St.

08193

CERTIFICATE OF DEATH

08179

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham		c. LENGTH OF STAY in 1b 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. STREET ADDRESS Graceham	
3. NAME OF DECEASED (Type or print) Leslie R. Sovocool First Middle Last		4. DATE OF DEATH June 18 19 67 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-1902
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public school	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Sovocool		14. MOTHER'S MAIDEN NAME Carrie M. Hesser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-8070	
17. INFORMANT Clara E. Sovocool		Address Graceham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH immediate + 2 yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — — — — —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-67 , 19 to 6-78 , 1967, that (I) (we) last saw the deceased alive on 6-7-67 , 1967, and that death occurred at 4P M, from causes and on the date stated above.			
22a. SIGNATURE Thomas A. Love		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas A. Love		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-22-67	23c. NAME OF CEMETERY OR CREMATORY Graceham Cemetery	23d. LOCATION (City or Town) (County) (State) Graceham, Md. Fred Co.
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR Raymond E. Creager	
25b. REGISTRAR'S SIGNATURE Raymond E. Creager		25c. DATE JUN 22 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08194

08180

1. PLACE OF DEATH a COUNTY <u>Frederick</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Frederick</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Frederick</u>		c LENGTH OF STAY IN 1b <u>?</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u> 104		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Reich's Ford</u>			d STREET ADDRESS <u>R.D. 4</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>ROBERT J. THOMAS</u>			4 DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1967</u>		
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 30, 1954</u>	9 AGE (In years last birthday) yrs <u>13</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>	
13 FATHER'S NAME <u>Ernest Stitley</u>			12 COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16 SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mr. Ernest Ritz 301 E. AS 70</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Suffocation</u> (c) <u>Drowning</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell into 8' hole in river - could not swim</u>			
20c TIME OF INJURY Month, Day, Year Hour <u>12:30</u> p.m. <u>6-25-1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home form factory, street, office, etc.) <u>River</u>		20f (City or town) (County) (State) <u>Frederick-Frederick Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Robert J. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>6-25-67</u>	
EXAMINER'S NAME (Type) <u>ROBERT J. THOMAS, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>6/25/1967</u>	23c NAME OF CEMETERY <u>Locust Grove</u>		23d LOCATION (City or Town) (County) (State) <u>Frederick Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>		25a REC'D BY REGISTRAR <u>JUN 28 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08195

CERTIFICATE OF DEATH

08181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Infirmary		d. STREET ADDRESS Resident (Montevue)	
3. NAME OF DECEASED (Type or print) ANDREW FLEMING STRATHERN		4 DATE OF DEATH Month 6 Day 6 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/22/OI 9 AGE (In years last birthday) 37 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee B&O R.R.		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Bathgate Scotland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Andrew Strathern		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 705-14-1600	
17 INFORMANT Nelson Strathern		Address Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio-sclerotic C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 years 10 years
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1 , 19 63 to June 6 , 19 67 that (I) (we) last saw the deceased alive on June 5 , 19 67 , and that death occurred at 12:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Seward C. Thomas Jr		22b. DATE SIGNED 6/8/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/9/67	23c. NAME OF CEMETERY OR CREMATORY Park Heights	23d. LOCATION (City or Town) (County) (State) Brunswick Md.
24. FUNERAL DIRECTOR Feete Funeral Home		25. REC'D BY REGISTRAR JUN 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

08196

CERTIFICATE OF DEATH

08182

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Havaco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle Last Stroupe		4. DATE OF DEATH Month June Day 26 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/01
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Dickens		14. MOTHER'S MAIDEN NAME Francese Groseclose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 233-87-8445	
17. INFORMANT Paul Stroupe - Brunswick Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute congestive heart failure 253X DUE TO (b) Anemia, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypothyroidism		INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs 2-3 yrs ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26 June 1967 to 26 June 1967 , that (I) (we) last saw the deceased alive on 26 June 1967 , and that death occurred at 7:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Henry V Chase		22b. DATE SIGNED 26 June 67	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase MD		22d. ADDRESS 804 Toll House Ave Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-30-67	23c. NAME OF CEMETERY OR CREMATORY Jaeger Memorial Cem.	23d. LOCATION (City or Town) (County) (State) Roderfield West Va.
24. FUNERAL DIRECTOR Feele Funeral Home		25a. REC'D BY REGISTRAR JUN 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 0 27

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

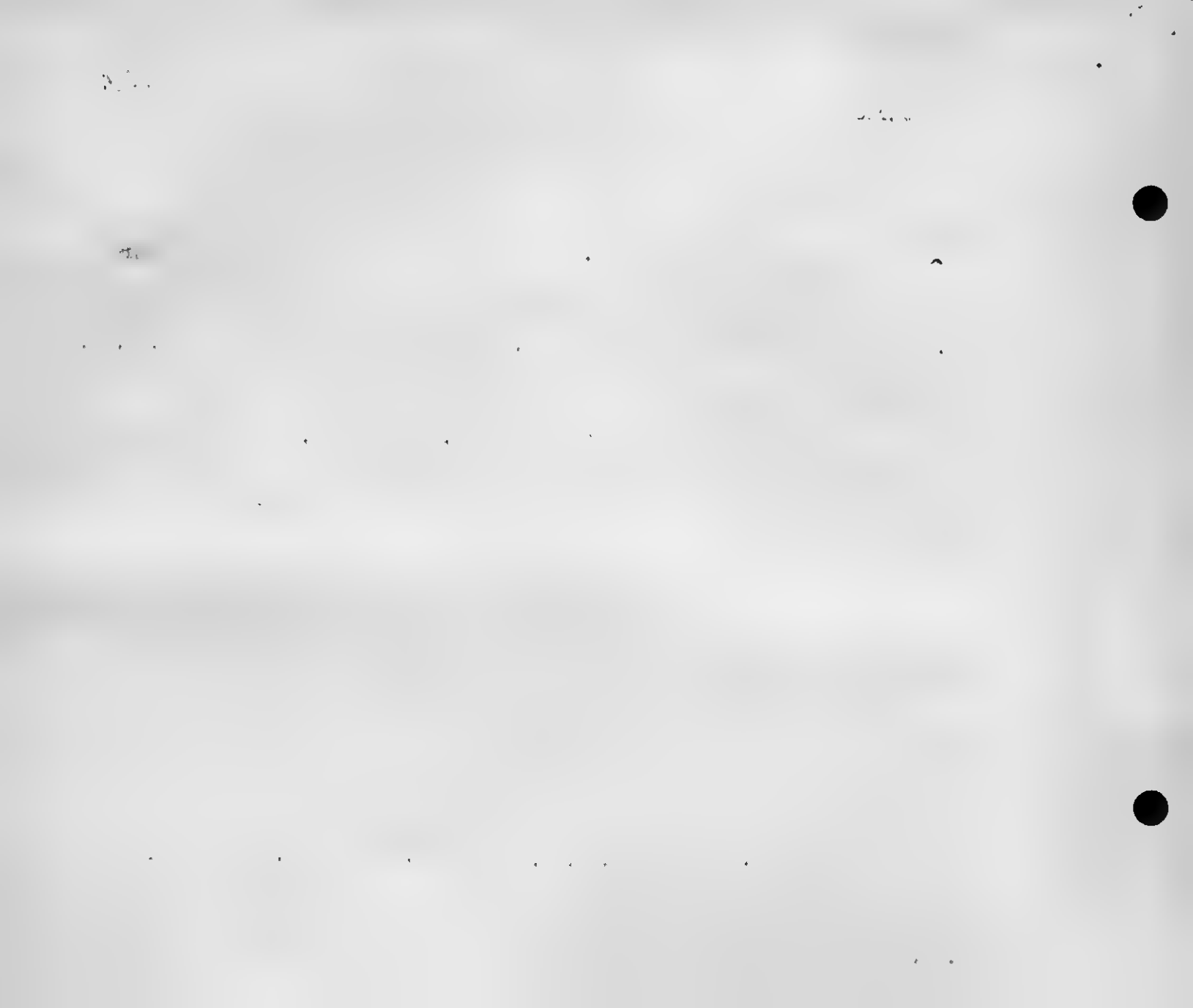
08197

CERTIFICATE OF DEATH

08183

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>600 Military Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>600 Military Road</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret C. Warner</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 26, 1921</u> 9. AGE (In years last birthday) <u>46</u> yrs.		4. DATE OF DEATH <u>June 19, 1967</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supv. Telephone Office</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bears Roebuck Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Woodsboro, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		PER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
13. FATHER'S NAME <u>Clyde Bentz</u> 14. MOTHER'S MAIDEN NAME <u>Lottie Kaufman</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>217 12 2069</u> 17. INFORMANT <u>Wilbur D. Warner, Sr. (Same as item #2)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - lungs</u> DUE TO <u>8 June</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinoma breast</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 19 <u>49</u> to <u>June 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 19</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.				
22a. SIGNATURE <u>Bernard O. Thomas Jr</u> 22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, Jr. M. D.</u>		22b. DATE SIGNED <u>June 21, 1967</u> 22d. ADDRESS <u>228 N. Market St. Frederick, Maryland</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>June 22, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> 25a. REC'D BY REGISTRAR <u>JUN 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08198

CERTIFICATE OF DEATH

08184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 101 Prospect Road	
3. NAME OF DECEASED (Type or print) First DANIEL Middle D. Last WILSON, SR.		4. DATE OF DEATH Month June Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Nov. 29, 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse R. Wilson		14. MOTHER'S MAIDEN NAME Mary K. Duvall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-6348A	
17. INFORMANT Mr. Daniel D. Wilson, Jr.		Address Mt. Airy, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 5020 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Chronic bronchitis and emphysema			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) alcoholism			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (This hospital) attended the deceased from 6/9/67 , 19__ to 6/10/67 , 19__, that (1) (we) last saw the deceased alive on 6/10/67 , 19__, and that death occurred at 12:00 P. M, from causes and on the date stated above.			
22a. SIGNATURE A. Austin Pearre, Jr.		22b. DATE SIGNED 6/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre, Jr.		22d. ADDRESS 4 E. Church St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/13/1967	23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Co., Md.
24. FUNERAL DIRECTOR Waltz		25a. REC'D. BY REGISTRAR JUN 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Box 241 Sykesville, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
08193						08185							
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY Frederick			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			a. STATE Maryland			b. COUNTY Frederick				
c. LENGTH OF STAY IN MD 20 years			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 507 Grant Place			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			d. STREET ADDRESS 507 Grant Place				
3. NAME OF DECEASED (Type or print) John W. Wolf						4. DATE OF DEATH June 22- 19 67							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29-1885		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Assoc. Cigar Factory				11. BIRTHPLACE (County & State, or foreign country) York Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Michael Wolf						14. MOTHER'S MAIDEN NAME Not available							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 186-01- 0427		17. INFORMANT Mrs. Lydia M. Ness Wolf-507 Grant Place-							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute coronary occlusion													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Hypertensive + arteriosclerotic Heart Disease													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro vascular Thrombosis - rt. hemiplegia since 1960													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)				(County)				(State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 29, 1958 to JUNE 22, 1967 , that (I) (we) last saw the deceased alive on MAY 19th 1967 , and that death occurred at 7:10p from the causes and on the date stated above.													
22a. SIGNATURE Raff L. Michels						22b. DATE June 23-67			22c. PHYSICIAN'S NAME (Type) Dr. R.L. Michels				
22d. ADDRESS Frederick Medical Center-Frederick, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 26-1967		23c. NAME OF CEMETERY OR CREMATORY Red Lion Cemetery				23d. LOCATION (City, town or county) (State) Red Lion- Pennsylvania			
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son						25a. REC'D BY REGISTRAR Elwood T. Whitmore			25b. REGISTRAR'S SIGNATURE Charles Judge				
25c. ADDRESS Frederick, Md. 21701						25d. DATE JUN 26 1967							

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10/1/1968